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From the Inside Out: A Critical Ethnographic Look at Paediatric Intensive Care Nursing and the Determinants of Nurse Retention

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***From the Inside Out: A Critical Ethnographic Look at Paediatric Intensive Care
Nursing and the Determinants of Nurse Retention***

Paula Rose Mahon

A thesis submitted for the degree of Professional Doctorate in Health

University of Bath

Department of Health

December, 2011

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Paula Mahon

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Title of the Project

From the Inside Out: A Critical Ethnographic Look at Paediatric Intensive Care Nursing and the Determinants of Nurse Retention

Abstract

The aim of this study is to examine key features within the cultural context in a Canadian Paediatric Intensive Care Unit (PICU) environment as experienced by nurses, and to identify what these influences are and how they shape nurses' intentions to remain at critically ill children's bed-sides for the duration of their careers.

This is a qualitative study which follows a critical ethnographic approach. Over 20 hours of observation and face-to-face semi-structured interviews were conducted. Approximately one third of the nursing population at the research site PICU were interviewed ($N=31$).

Participants describe a complex process of becoming an expert PICU nurse that involved several stages. By the time participants became experts in this PICU they believed they had significantly narrowed the power imbalance that exists between nursing and medicine. This study illuminates the role both formal and informal education plays in breaking the power barrier for nurses in the PICU. This level of expertise and mutual respect between professions aids in retaining nurses in the PICU. The lack of autonomy and/or respect shown to nurses by administrators appears to be one of the major stressors in nurses' working lives and can lead to attrition from the PICU.

Family Centred Care (FCC) is practiced in paediatrics and certainly accentuated in the PICU as there is usually only one patient assigned per nurse, who thus afforded the time to provide comprehensive care to both the child and the family. This is considered one of the satisfiers for nurses in the PICU and tends to encourage retention of nurses in the PICU. However, FCC was found to be an inadequate term to truly encompass the type of holistic care provided by nurses in the PICU.

Abbreviations

CE: Critical Ethnography

CNS: Clinical Nurse Specialist

CNC: Clinical Nurse Co-ordinator

CST: Critical Social Theory

DC: Demand-Control

EL: Emotional Labour

FCC: Family Centred Care

NICU: Neonatal Intensive Care Unit

PICU: Paediatric Intensive Care Unit

SCCM: Society of Critical Care Medicine

TCU: Tertiary Care Unit

Glossary

Auditability: This refers to the enabling of another researcher to clearly follow the 'decision trail' used by the investigator. In addition, another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective, and situation (Sandelowski, 1986 and Lincoln & Guba, 1985).

Burnout: Burnout is a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind (Maslach, 1981).

Capital: This is a range of resources in many forms. Those most frequently referred to are social, material, cultural and symbolic. Capital is a resource drawn upon to gain entry to fields in order to navigate the social world. Value is assigned to capital through social processes and, as such, can be positive or negative (Lynam et al., 2007).

Confirmability: In qualitative research, this occurs when auditability, fittingness, and credibility have been established, based on engagement between researcher and subjects. Qualitative research values subjectivity rather than objectivity in two ways: the subjective involvement of investigators with their subjects; and the emphasis on subjective reality or the meanings subjects give to and derive from their life experiences. Engagement with rather than detachment from the things to be known is sought in the interests of truth. Qualitative researchers acknowledge the complexities of this kind of involvement with subjects but view the benefits as far outweighing the liabilities (Sandelowski, 1986 and Lincoln & Guba, 1985).

Credibility: In qualitative research, this means presenting '*such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it . . .*' Sandelowski (1986:30). Also, it applies when others can recognise the experience by reading about it (Sandelowski, 1986 and Lincoln & Guba, 1985).

Critical Ethnography: The evolution of ethnography is critical ethnography. While ethnography represents an apolitical interpretation CE is embedded with values.

Thomas (1993a) believes that CE is a style of analysis rooted in conventional ethnography. CE focuses on raising consciousness and aiding emancipatory goals to effect social change (Polit & Beck, 2004). It extends the boundaries of ethnography (the examination of culture within the social setting) and has been termed a hybrid of ethnography (Roberts & Taylor, 2002; Seal, 1999; Street, 1992; Taylor et al., 2007).

Culture: Landy (1977) describes the medical system as having ‘*A cultural aspect, which includes certain basic concepts, theories, normative practices and shared modes of perception (1977:511)*’. Helman (1990) reminds one that a health care system does not exist in a social or cultural vacuum. Helman continues by noting that a health care system usually represents the ideologies of the society from which it stems.

Data Saturation: Data saturation is the situation in which the data have been heard before. For example, a researcher might interview 23 people who all had the same experience (same disease, same job, same lifestyle, etc.). If the researcher only interviews a small number of participants their personal nuances and characteristics will colour the findings. On the other hand, there is no need to continue interviewing people once the researcher finds that further interviews are not adding to the findings, or are repeating what was already found in the previous interviews (Sandelowski, 1986 and Lincoln & Guba, 1985).

Emic View: The *insider’s* view is described as the *emic* perspective.

Etic View: The view of the *outsider* is considered to be the *etic* perspective

Family-Centred Care: This is made up of a set of values, attitudes, and approaches to services for children with special needs and their families. Family-centred service recognises that each family is unique; that the family is the constant in the child’s life; and that family members are the experts on the child’s abilities and needs. The family works together with service providers to make informed decisions about the care and support provided for the child and family. In family-centred service, the strengths and needs of all family members are considered (Law, 2003).

Field: This represents the broader social context. It refers more generally to social terrain. Fields are contexts in which we interact and refer to both physical and social spaces. The concept of field directs the analyst to focus attention on processes such as gaining entry and navigating the social terrain of relationships (Lynam et al., 2007).

Fittingness: In qualitative research, this is when findings ‘fit’ into contexts outside the study situation and when the audience views the findings as meaningful and applicable in terms of their own experience (Sandelowski, 1986 and Lincoln & Guba, 1985).

Generalisability: *‘The word ‘generalisability’ is defined as the degree to which the findings can be generalised from the study sample to the entire population’ Polit & Hungler, (1999: 645).* CE is not generalisable in this sense; however, according to Adelman, Jenkins, and Kempis (1980), the knowledge generated by qualitative research is significant in its own right.

Habitus: A set of dispositions which generate practices and perceptions.

Paediatric Intensive Care Unit: For the purpose of this study, a paediatric intensive care unit (PICU) is defined as *‘a hospital facility for provision of intensive nursing and medical care of critically ill children, characterised by high quality and quantity of continuous nursing and medical supervision and by use of sophisticated monitoring and resuscitative equipment’* (On- line Medical Dictionary, 2000).

Tacit Knowledge: Tacit Knowledge is *‘information about the culture that is so deeply embedded in cultural experiences that members do not talk about it or may not even be consciously aware of it’* Polit & Hungler, (1999: 245).

Thick Description: Thick description is described as a way of achieving a type of external validity. By describing a phenomenon in sufficient detail one can begin to

evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people (Lincoln & Guba, 1985).

Unobstructive Observation: This type of observation is carried out without the explicit awareness and agreement of the subjects being observed (Carspecken, 1996)

CHAPTER 1: INTRODUCTION TO THE STUDY

In developing this study, the author has been informed by her background as a nurse practising in a Paediatric Intensive Care Unit (PICU). The research site is a 22-bed unit, located in Western Canada. This PICU is plagued by a persistent nursing shortage; the PICU has lost approximately 20% of its PIC-trained registered nurses in each of the past two years (2008-10 – *internal management data records* – *personal correspondence*). This lack of qualified nurses in the PICU has led to an increase in the rate of cancellations of surgical and medical procedures, which prolongs wait times and means that children are not getting the timely care they need. It is crucial to establish why nurses are leaving and what makes them stay in the PICU.

Over the last twenty years, health care in North America and Europe has been plagued with a shortage of nurses (WHO, 2003). In Canada, various strategies have been used to address this problem: nurses have been recruited from third world countries, and nursing schools have increased their admission numbers (Aiken, Buchan, Sochalski, Nichols & Powell, 2004).

The shortage has been blamed on poor remuneration, lack of autonomy or respect in the workplace, over-work, and burnout (Duquette, Kācrowc, Sandhu & Beaudet, 1994). However, the majority of this research has been conducted in adult units. Paediatric Intensive Care is a highly stressful, fast paced environment which is increasingly difficult to staff (Bartz & Maloney, 1986 and Bratt, Broome, Kelber & Lostocco, 2000). Although difficulties in recruitment and retention are well documented, little research has addressed how the cultural or environmental context of a PICU contributes to nurses' intentions to remain in or leave bed-side nursing in PICU's. This study investigates this phenomenon.

From a PICU perspective this work is exploratory, as the broad literature is limited on how PICU environments affect nurses' intentions to remain at critically ill children's bed-sides for the duration of their careers.

Critical Ethnography (CE) is the guiding methodology of this study. The study was conducted in a PICU at a tertiary care paediatric hospital in western Canada. Data was collected through unobtrusive observation and interviews with PICU nurses. Relevant documents have been entered into the data set, including field notes from the researcher's reflective journal (Madison, 2005). A stratified purposive sample of currently employed PICU nurses was interviewed using semi-structured interviews. Analysis of the data was inductive in nature and concurrent with data collection. The rationale for choosing CE is described, as is the study design, including sampling, data collection, data analysis, protection of human rights, assumptions, and limitations.

This work is potentially important to consider in the context of child health care. The World Health Organization emphasises the importance of child health in particular (WHO, 2005). It should follow that we direct our attention in health care research to investigate the care of children both in institutions and in the home. This work focuses on children in institutions, especially in a PICU where children are physically and emotionally most vulnerable.

Focus of the Study

At the outset of the study, it was recognised that PICU environments are unique and not well understood. The influence this environment has on staff, in particular the nurses, requires investigation. The most appropriate method to do this is to give these nurses a voice; to let them tell their own story. This will encourage the nurses to consider and articulate the influences this environment has on them. Brickhouse and Potter (2001) and Holland (1998) propose a fluid view of identity, in which a person's identity evolves in response to his/her '*structure and power relations*' (1998:966), past experiences, present context, and developing aspirations.

Brickhouse and Potter note, '*Although the process of identity development is an individual one, it is a process that is socially situated, giving rise to meanings and positionings that are part of the social world*' (2001:444). Expressing voice is a tool for agency. Vora and Calabrese Barton (2006) define agency as '*individuals or groups acting upon, modifying, and/or giving significance to the world in purposeful ways, with the aim of creating, impacting and/or transforming themselves and/or the*

conditions of their lives.' (2006: 890). Agency can be personal (Blackburn, 2004) - focused on improving oneself or one's own circumstances - or have the potential to influence large scale social change (Danns, 2002).

Purpose of the Research – The Research Question

How do the environmental features of Paediatric Intensive Care (PIC) influence nurses' intentions to stay in or leave bed-side nursing?

Aim of the Research

The aim of this work is to identify key features of the cultural context of the PICU environment as experienced by nurses, and to examine what they are and how these influences shape nurses' intentions to continue in or to leave nursing in this environment.

Objectives of the Research

1. To elucidate the culture of the PICU nurses' work environment.
2. To ascertain how environmental features of a PICU encourage or deter participant nurses from remaining at the bed-side by exploring the relationships between nurses and their work environment through observation and interviews.
3. To assess the extent to which insights into PICU nurses' experiences may give employers and managers conceptual guidance in their efforts to critically analyse their own environments in order to improve retention of nurses.
4. To serve as a foundation for further research within the PICU context.

The question being asked by this research is not only why PICU nurses leave the bed-side but why they stay, and what within the cultural environment might influence this decision. Asking nurses what compels them to work in a given area, why they stay, and what it would take to make them leave the bed-side will accomplish this aim. We need to understand how nurses in the PICU view their environment, and how they manage to resolve the contradictions associated with power, knowledge and professional identity. Understanding how nurses view power, education and their own position within the PICU context will enhance our ability to recruit and retain highly qualified PICU nurses.

Structure of the Thesis

This thesis is comprised of six chapters that describe the process of the study

- Chapter One introduces the study. The focus, aims and objectives of the research are described. Finally the structure of the thesis is outlined.
- Chapter Two summarises existing theory and research related to the nursing shortage, burnout in nurses, paediatric critical care nursing; and the researcher articulates the philosophical position of the study. This location provides the rationale for the methodological choices made in the design of the study.
- Chapter Three describes the design of the study and explains the rationale for selection of a particular methodology selection. Data collection and analysis are also described, and the reflexivity and ethical issues and limitations of this methodology are discussed.
- Chapter Four commences with a review of the aim of this study and an overview of the empirical findings. The author attempts to understand the environmental influences of a PICU and how they may affect a nurse's decision as to whether he/she will stay in a PICU. The outcome of the author's critical ethnographic analysis is presented. She discusses becoming an expert PICU nurse, undergoing peer review, entering the inner sanctum and being an expert; from her research it became apparent that becoming a PICU nurse is a process. This process is explored in this chapter. The conflicts and contradictions found in the PICU environment are discussed from the nurses' perspective.
- Chapter Five discusses the broad, central tenets that appear to have an overarching influence on the PICU nurses' environment and are discussed in conjunction with theoretical findings. These tenets are: Trust, Communication and Burnout. The author presents new insights from the findings and analysis in relation to the PICU and the influence these findings may have on PICU nurses and the existing literature.
- Chapter Six summarises the thesis and describes the possible implications for employers and PICU nurses when it comes to retaining PICU nurses. The limitations of the study are presented and finally, recommendations are made for further study.

CHAPTER 2: LITERATURE REVIEW - Philosophical, theoretical and empirical background to the project

Introduction

The World Health Organization has described the critical state of nursing shortages and the need for this to be addressed. Studies have shown (Rafferty et al., 2010) that low nurse staffing levels correlate to increased mortality and morbidity.

The aim of this chapter is to examine the literature on the nursing shortages and efforts to address this issue. It will focus on the causes of the nursing shortage and the culture of a PICU. This examination of the literature will demonstrate the need for further research in this area by identifying gaps in the research, and thus avoid repetition or redundancy of research findings.

Chapter Two identifies varying stresses on nurses. The literature demonstrates that there is very little work on the PICU nursing environment or on why the PICU nurse may stay in or leave her/his employment in PICU. The literature referenced shows the impact of burnout and job dissatisfaction on nurses. Power, knowledge and trust as they pertain to nurses are also discussed.

Background

The looming nursing shortage was recognised in the early 1980s. The World Health Report in 2003 noted: *'The most critical issue facing health care systems is the shortage of people who make them work' (2003:3)*. The World Health Organization (WHO, 2003) described the overall scale of the shortages as 'staggering'. In a report on health systems, The Organization for Economic Co-operation and Development (OECD, 2008) highlighted concerns about nursing shortages in many OECD countries. This report notes: *'Nursing shortages are an important policy concern in part because numerous studies have found an association between higher nurse staffing ratios and reduced patient mortality, lower rates of medical complications and other desired outcomes' (2008:9)*. The report emphasises that the nursing shortage will worsen as the current workforce ages. Some recent examples of OECD

country assessments of nursing shortages include Canada, where the shortfall of nurses was quantified at ~78,000 nurses by 2011 (OECD, 2008).

The impact of the nursing shortage can have a profound effect on patient outcomes. The U.S. component of the International Hospital Outcomes Study (Aiken, Clarke, Sloane, Sochalski & Silber, 2002) documented a strong association between nurse staffing and mortality and showed that job dissatisfaction and burnout were associated with low staffing levels. This study showed that there was a 31% difference in mortality between hospitals in which registered nurses cared for 8 patients each and those in which nurses cared for 4 patients each (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). The Canadian component of this study showed that a staffing skill mix with a higher proportion of registered nurses was associated with lower mortality (Estabrooks, Midodzi, Cummings, Ricker & Giovannetti, 2005).

In 2010 Rafferty et al. published the results of a cross-sectional analysis of survey data and discharge records; this study showed that patients in hospitals with the higher patient to nurse ratios had higher mortality; the nurses were twice as likely to be dissatisfied with their jobs and to have associated high burnout levels. Patients and nurses with the lowest patient-to-nurse ratios had better outcomes than those in hospitals with less favourable staffing. The Kendall-Gallagher and Blegen (2010) study suggests that nurses' level of knowledge and judgement appear to play a role in the prevention, mitigation, and creation of adverse events that place patients at risk for harm in intensive care units. Thus not having sufficient specialised nurses in intensive care would be a significant patient safety concern.

Efforts to Address the Nursing Shortage

In Canada, various strategies have been used to address this problem: nurses have been recruited from developing countries and more nursing schools have opened (Acree, 2006; Aiken et al., 2004; Aiken et al., 2001). Over the last several years, international recruitment of nurses has become more common. Although nurses moving across borders is not a new phenomenon (Kingma, 2008), in recent years active recruitment by employers from developed countries facing nursing shortages

has increased. However, in developing countries, the practice of 'active' recruitment has generated controversy because of the potential to cause nursing 'brain drain' (Aiken et al., 2001). Additionally there is internal migration of nurses – from public sector to private sector employment, and from nursing to non-nursing or no employment (Kingma, 2008).). Blegen (2008) was the first study to show that hospital (nurse) staffing levels on both intensive care and non-intensive care units decrease as the supply of nurses in the surrounding geographic area decreases. This can have impact on staffing levels in urban areas if staff move out of urban to suburban areas for financial reasons and vice versa.

Potential Factors Leading to the Nursing Shortage

The proposed causes of the shortage include poor remuneration, lack of autonomy and respect in the workplace, death and dying, over-work, and burnout (Bartz, C. et al. 1986; Beaver, Sharp & Cotsonis, 1986; Ceslowitz, 1989; Chiriboga & Bailey, 1986; Harris, 1989). Maslach and Jackson (1981) noted *'that those in the helping professions who work continuously with people who are ill may suffer from chronic stress which can be emotionally draining and cause burnout.'* (1981:99).

Key aspects of burnout syndrome (Maslach & Jackson, 1981):

- Increased feelings of emotional exhaustion leading to feeling that the employee is no longer able to give of themselves at a psychological level.
- The development of negative, cynical attitudes and feelings about one's clients. This may be linked to the experience of emotional exhaustion.
- This dehumanised perception of others can lead staff to view their clients as somehow deserving of their troubles (Ryan, 1971). The prevalence among human service professionals of this negative attitude toward clients has been well documented (Wills, 1978).
- The tendency to evaluate oneself negatively, particularly with regard to one's work with clients. Workers feel unhappy about themselves and dissatisfied with their accomplishments on the job.

The consequences of burnout are potentially very serious for staff, patients and the institution itself. Maslach's original research on burnout (Maslach, 1976, 1978a,

1978b, 1979; Maslach & Jackson, 1979; Jackson & Maslach, 1981; Maslach & Pines, 1977; Pines & Maslach, 1978, 1980) suggests that burnout can have a negative effect on quality of care, and appears to be a factor in job turnover, absenteeism and low morale. They found evidence that burnout has some correlation with personal distress, physical exhaustion, insomnia, increased use of alcohol and drugs, and marital and family problems. Mobley (1977) and Landstrom, Biordi & Gillies (1989) hypothesise that several other variables affect the relationship between job satisfaction and intent to stay, but that intent to leave precedes termination.

Maslach's primary research was exploratory in nature. However, the consistent nature of the findings led her '*to postulate a specific syndrome of burnout and to devise an instrument to assess it*'. Maslach's Burnout Inventory (MBI) (1981) was designed to measure aspects of the burnout syndrome. This measure contains three subscales (*see Table 1*) describing the different aspects of experienced burnout and has been found to be reliable, valid, and easy to use (Maslach et al., 1981).

Table 1: Maslach's Burnout Inventory Subscales (1981)

- | |
|--|
| <ul style="list-style-type: none">• Emotional Exhaustion• Personal Accomplishment• Depersonalization |
|--|

In 1994 a literature review of the existing data regarding factors related to burnout in nurses was conducted (Duquette et al., 1994). The authors found that the best correlates of nursing burnout are role ambiguity, workload, age, hardiness, active coping, and social support. Duquette et al. found that burnout is a complex phenomenon with multiple dimensions which are adding to nursing attrition. The authors identified that demographic factors such as age, nursing grade and experience appear to be linked to burnout in nursing.

Borda & Norman (1997) reviewed the nursing literature to identify the factors with the greatest influence on turnover of qualified nurses. This review identified intent to stay in current employment as the variable with the greatest influence on turnover. Intent to stay is associated with job satisfaction (Mealer, Burnham, Good, Rothbaum & Moss, 2009). The review of the turnover literature conducted between 1971 and 1996 by Borda et al. shows that job dissatisfaction is widely regarded as the major contributor to turnover amongst nurses (Mealer et al., 2009).

A recent study (Lai et al., 2008) conducted in Taiwan looked at the factors that influence nurses' intention to leave the bed-side. A cross-sectional predictive study was performed with 130 nurses recruited from two ICUs. Lai et al. believe that if the predictors of intention to leave are understood, more appropriate recruitment and retention strategies can be developed. They identified general job satisfaction, general job happiness, satisfaction with salary, education background, work overload, conflict in the workplace, and lack of social support correlated with nurses' intention to leave their jobs.

The theoretical history of employee turnover is steeped in the study of industrial–organisational psychology and organisational behaviour (Ramesh, 2010). Job embeddedness is the degree to which individuals or firms are enmeshed in a social network. The concept was introduced by sociologist Mark Granovetter (1985). Mitchell, Lee and colleagues call it a theory of staying (Mitchell, Holtom & Lee 2001; Lee, Allen, Meyer & Rhee, 2004). Job embeddedness suggests that the more a person is connected to an organisation and community, the more likely he/she is to remain in that organisation/community. Mitchell et al. demonstrated that people leave their jobs not just because of negative affect (e.g. lack of job satisfaction, job involvement, organisational commitment), but because of a variety of precipitating events. These events are known as shocks. While each experience is unique, Lee and colleagues (1999, 2001) found that people follow one of four psychological and behavioural paths when quitting (shocks, scripts, image violations, job dissatisfaction). The latter three of these four paths are initiated by shocks. A shock can be positive, neutral, or negative; expected or unexpected. If an individual's values or goals do not fit with those of the employing organisation or those implied

by the shock, an image violation occurs. A person can become enmeshed or embedded in a variety of ways (both on and off the job). The critical aspects of job embeddedness are the extent to which the job is similar to or fits with the other aspects in their life space, the extent to which the person has links to other people and how easy it would be to break those ties. These dimensions are called fit, links and sacrifice. Job embeddedness focuses on the overall level of connectedness (Mitchell et al., 2001). Job embeddedness assumes that the better the fit, the higher the likelihood that an employee will feel professionally and personally tied to the organisation (Mitchell et al., 2001).

Researchers have identified many reasons for job dissatisfaction, (Bjork Samdal, Hansen, Torstad & Hamilton, 2007; Bland-Jones, 2005; Borda & Norman, 1997; Boyle, Bott, Hansen, Woods & Taunton, 1999; Bratt et al., 2000; Freeman & O'Brien-Pallas, 1998 and Goehner, 1992) but the majority of this work was conducted with nurses working in adult environments. The PICU nurse's perspective has been paid very little attention. Bratt et al. (2000) conducted an extensive study in PICUs across Canada and the USA using a cross-sectional survey based on the already identified threats to job satisfaction (see Maslach's list above), asking nurses to rate these threats in order of importance. The only additional data derived from this work was that nurse-family interactions may add to job-related stress in the PICU. The consistent theme throughout all of the research projects above is that threats to job satisfaction are objectively quantifiable. Wainwright & Calnan (2002) raise concerns about the validity of self-reported data acquired from questionnaires about work stress and suggest that these types of studies do not provide an accurate, objective measure of work characteristics. They note that attempts have been made to overcome these short-comings by using expert observers to calibrate job characteristics. However, Wainwright & Calnan conclude that: *'The Claim that such differences can be objectively quantified is based on the epidemiological fallacy that pathogenic agents can be absolutely separated from the characteristics of the host. This may be valid in the case of an infectious disease like cholera or meningitis. It may even be appropriate to studies of physical or mental fatigue. But it becomes highly questionable when applied to the measurement of psycho-social stress, where*

the characteristics of the job and those of the individual worker are far more closely bound.' (2002: 54).

Since Maslach developed a methodology and tool to measure burnout in nurses in 1981, several other similar tools have been developed to investigate burnout, such as 'The Posttraumatic Diagnostic Scale' (Foa, Cashman, Jaycox & Perry, 1997) and Karasek's (1979) demand-control-support (DCS) model which is another method to measure work stress. This model is used in occupational health research. Karasek notes that the work environment is a combination of job demands and job control. The combination of high job demands and low job control (high-strain jobs) is believed to result in stress reactions, such as low job satisfaction (Karasek, 1979; Karasek & Theorell, 1990). This would appear to fit for the PICU. As will be shown in this research, PICU nursing might plausibly be hypothesised as a high-demand, low-control working environment. This supports the concept of PICU as a stressful environment that will affect the nurses' level of job satisfaction and thus the desire to remain in a high stress area such as PICU.

Siegrist et al. (2004) state that effort-reward imbalance further supports the belief that job dissatisfaction and burnout are the major influences on why staff may leave high stress areas such as the PICU. In Siegrist's model, chronic work-related stress is identified as a response to low reciprocity or imbalance between high efforts spent and low rewards received. The adverse health effects of effort-reward imbalance have been documented in several investigations (Siegrist et al., 2004). One such study among German nurses tested the hypothesis that an imbalance of high job demands and low rewards, such as poor promotion prospects, are associated with burnout (Bakker, 2000).

While the job strain models discussed above appear to be applicable to the question of why PICU nurses decide to stay at or leave the bed-side, no significant research project has yet been applied to them in this context. The vast majority of research to date has been conducted in adult units. Most likely this is because paediatrics constitutes such a small amount of all hospital patients. However, as children are the future of our community it should follow that their well-being and thus the well-

being of their carers should be considered in health care research - as advocated by *The World Health Report (WHO, 2005) - Make Every Mother and Child Count*.

If nurses are burning out then why do some nurses stay for prolonged periods in PICU? The consistent theme throughout all of the research projects above is that threats to job satisfaction have all been identified. That is, the job strain models research has used a deductive approach (basing questionnaires on existing theory), rather than an inductive one (asking nurses their opinions on the subject). Asking nurses what compels them to work in a given area and what it would take to make them leave the bed-side may be more informative. Foglia, Grassley, and Zeigler (2010) suggest that a study should be conducted to determine why nurses are staying in their PICU jobs. Job retention in PICU should not be viewed as an unmediated response to objective job characteristics, but a culturally mediated response which depends upon how nurses invest their experiences with meaning through interaction with others. Thus, a significant gap in the literature exists regarding PIC nursing turnover (Foglia et al., 2010). This research addresses that gap. The question being asked by this research is not only why PICU nurses leave the bed-side but why they stay, and what environmental conditions might influence this decision.

Why is Paediatric Intensive Care Nursing Different from Other Nursing Practice Areas?

Since the 1950s, paediatrics has been recognised as a separate patient population, requiring different and separate specialist care (Barnsteiner, Richardson & Wyatt, 2002). The PICU grew out of a need for increasingly complex postoperative management for children, following advances in surgical procedures and development of advanced life-support technology (Epstein & Brill, 2005). The subspecialty of the PICU followed the establishment of paediatric hospitals (Downes, 1992). The first PICU was established in Europe by Haglund in 1955 in Sweden. The Society of Critical Care Medicine (SCCM), representing the adult intensive care community in North America, recognised the PICU as discrete and different from adult units and thus created the section of PICU within the SCCM in 1981 (Downes, 1992). In 1983, guidelines defining the minimal requirements for PICUs were introduced by the Committee on Hospital Care and the Paediatric Section of the

SCCM. Paediatric nursing is '*not "med-surg nursing" on little people*' (Feeg, 1995). Knowledge of child development, the physiological differences between children and adults, and of specific paediatric disorders is required (Wong, Hockenberry, Wilson, Winkelstein & Kline, 2003). An additional requirement for a PICU is family centred care, recognising the vital role that families play in children's lives with respect to wellbeing, growth and development; this must be reflected in children's care when they are ill (Feeg 1995; SPN 2003). Family-centred care involves the nurse collaborating with families (SPN, 2003). The term Family Centred Care (FCC) is derived from Carl Rogers' work in the 1930s with families of 'problem' children (Rogers, 1939). The Association for the Care of Children in Hospitals was founded in the United States in the 1960s to promote a more holistic approach to care for hospitalised children, particularly in terms of psychosocial issues and family involvement. Much of the literature on family-centred care has come from the family support and early intervention fields (Dunst, Johanson & Trivette, 1991). More recently, family-centred service has been applied to the field of paediatric rehabilitation (King, Rosenbaum & King, 1997; King, Law & King, 1998; King, King & Rosenbaum, 1999; King, Kertoy & King, 2000). The role of the family in the child's life, and the importance of the insights of parents into their child's abilities and needs have become more recognised by professional caregivers. King (1996) describes three important aspects of care giving: information exchange, respectful and supportive care, and partnership or enabling. These aspects are fundamental to family-centred service according to King, Teplicky, King & Rosenbaum (2004):

- That parents know their children best and want the best for their children
- That families are unique and different
- That optimal child functioning occurs within a supportive family and community context.

In general, hospitals are considered stressful places to work (Mealer, Burnham, Goode, Rothbaum & Moss, 2009). The emotional factors associated with paediatric illness and the concepts of families and family centred care add dimensions to PICU that make it a unique area of interest for the purpose of research (McCallum, Byrne & Bruera, 2000; Meyer, Burns, Griffith & Truog, 2002; Miller, Forbes & Boyle, 2001).

Culture in the PICU

To understand the PICU we must see it within a cultural perspective. Landy (1977) describes the medical system as having '*A cultural aspect, which includes certain basic concepts, theories, normative practices and shared modes of perception.*' (1977: 511). Helman (1990) identifies that a health care system does not exist in a social or cultural vacuum; rather, a health care system usually represents the ideologies of the society from which it stems. Organisational culture is based on deeply ingrained beliefs, values and fundamental assumptions about the nature of the organisation, and about the roles of managers and employees (Helman, 1990). Culture within large organisations is neither universal nor consistent. Within each organisational culture are varying degrees of integration due to the existence of subcultures (Deal, 1998; Hagberg & Heifetz, 2000; LaBarre, 2001). Subcultures are groups of people who work as departments, units or teams, and may have unique values, norms, beliefs and assumptions (Kaufman, 1999). The way relationships are structured in health care organisations is informed by culture (Hagberg & Heifetz, 2000), with consequences affecting the overall satisfaction and quality of work life of health care workers (Canadian Council on Health Services Accreditation, 2004; Mallak, Lyth, Olson, Ulshafer & Saradone, 2003; Miller et al., 2001; Varcoe, Rodney & McCormick, 2003).

The complex subculture of the Neonatal Intensive Care Unit¹ (NICU) has been documented (Hunter, Spence, McKenna & Iedema, 2008). This subculture encompasses a set of subconscious beliefs, attitudes and assumptions that are shared by staff (Ohlinger, Brown, Laudert, Swanson S. & Fofah, 2003). A culture of PICU is implied but rarely explored in the literature. Curtis and Patrick (2001) identify 'saving lives' as the dominant culture of critical care. Many of the cultural forces noted by Kaufman (1999) are alluded to in findings from studies that examine how children die in PICU (Burns et al., 2001; Burns, Mitchell, Griffith & Truog, 2000; Feudtner et al., 2002; Garros, Rosychuk & Cox, 2003; McCallum et al., 2000; Meyer et al., 2002).

¹ Neonatal Intensive Care Unit (NICU) is a unit of a hospital specialising in the care of ill or premature newborn infants. The NICU provides a high level of intensive care to premature infants only; all other children are cared for in PICU.

In order to understand the culture of the PICU it would be fitting to consider the concept of *habitus* as described by Pierre Bourdieu (Bourdieu, 1986, 1990a, 1990b, 1998). Simply put, *habitus* refers to the things we do, the way we speak, how we act, and even the clothes we wear, to help us fit in to a particular group. It is a set or a schema. Such schemata develop over time. They are not formal rules or codes of conduct. However, they are adhered to and change over time.

Habitus is about fitting in; being part of a situation; not standing apart or being different; and by fitting into a particular social milieu one becomes distinctive. That is, by becoming a member of a particular group, wearing the uniform, hair style etc. one becomes distinctive as a member of that group from the rest of society. In tandem with *habitus*, Bourdieu describes the concepts of *field* and *capital*. *Field* represents the broader social context. This focuses the researcher's attention on gaining entry and exploring relationships. *Capital* is a range of resources that can be social, material, cultural and symbolic. The researcher uses *capital* to gain entry to *fields* to navigate the social world. These concepts intersect and encourage the researcher to observe influences on social relations and conditions (Bourdieu, 1986, 1990a, 1990b, 1998; Reay, 1998). Bourdieu's perspective facilitates understanding culture as experienced by the individual (Lynam, Browne, Reimer Kirkham & Anderson, 2007). Lynam et al., (2007) explain that Bourdieu also provides the researcher with conceptual tools to interpret how these social processes shape individual experience '*... Bourdieu's perspective that enables an analyst to write the person, and his or her response to situations, into the analysis. Analytic perspectives that foreground these dimensions of culture — culture as enduring, as negotiated, and as influenced by broader organisational structures — align with different theoretical traditions that include hermeneutics, social constructionism and structuralism.*' (2007:24). Nurse researchers have drawn on many theoretical traditions when examining culture and health. It is only in recent years that Bourdieu has been drawn upon to inform health research (Savage, 2003; Hall, 2004; Lynam, 2004, 2005; McKeever & Miller, 2004).

Bourdieu's work is suited to inform this research, as his perspective illustrates the different ways people's social location affects their life choices, and it can thus aid in advancing our understanding of cultural influences (Reed-Donahay, 2005). That is, Bourdieu's perspective allows us to understand how culture is embodied and experienced by the individual (Lynam et al., 2007). Bourdieu's analytic perspective will facilitate a more critical appraisal of 'culture'.

Bourdieu's thinking was based on multiple traditions from hermeneutics to cultural theory (Bourdieu & Wacquant, 1992; Robbins, 2000; Reed-Donahay, 2005). His writing has drawn attention to the perspectives of those who are not advantaged by the status quo, such as women, the poor, etc. *'Bourdieu's concepts foreground particular aspects of social relations and the forces that shape them. In our experience this serves to enable the analyst to unpack or explicate the socially embedded nature of day-to-day social interactions and to make visible the ways different societal practices, including 'traditions', assign value, shape gender relations, and shape and influence decision-making practices within organisations'* Lynam et al. (2007:28).

The concept of *habitus* and nursing *habitus* proved to be an excellent tool to aid in the researcher's understanding of power imbalances within nursing, and the potential influences nursing *habitus* may have on the nurse as an individual.

The culture of the PICU and its impact on a nurse's intention to stay at or leave the bed-side has not been explicitly examined. This study hopes to develop an in-depth interpretation of the nature of the experience of the PICU nurse's work environment.

Locating the PICU Nurse in the Broader Context of Hospital Culture

To understand the nurse as a professional within a hospital setting it is worth considering Henry Mintzberg's (Gabarro, 1992) organisational configurations. Mintzberg describes seven configurations into which characteristics of companies cluster, and how they should be treated or organised. They are: the simple, the machine, the professional, the divisional, the adhocracy, the missionary and the

political organisation. The author has briefly described four of these configurations here as they are the most relevant to this topic.

- The Machine Structure: As the name suggests, this is post-industrial revolution structure. The main emphasis in machine structure is on the performance of tasks. Tasks that need to be standardized, using low-skill but highly-specialised workers. This creates efficiency in task performance and eventual manufacturing of a product. This type of structure creates a need for a 'middle-line' hierarchy to oversee the specialised work. Top management usually maintains control. These companies tend to be mass producers, such as car companies.
- The Professional Structure: The professional organisation is a structure that includes a great number of professionals, such as a hospital. There is a significant support staff network in place. It tends to be democratic for the professionals, as they are relatively autonomous in their decision-making processes. It tends to create a decentralised structure. The professional structure has a need to standardise practice. Traditionally, hospitals would fall in to this category.
- The Divisional Structure: This type of structure is not an integrated organisation but it is a group of independent entities loosely joined by an administrative overlay. Therefore, it is not a complete structure. It is more a partial structure superimposed on another structure. This allows for divisions of an organisation to have autonomy without becoming decentralised. This fosters diversity and adaptability. Most 'Fortune 500' companies have this structure. More recently, hospitals have adapted this structure. In fact, Canadian health regions have moved in this direction, changing their structure from that of the professional structure to the divisional structure in an effort to save health care dollars (Juzwishin, 1992).
- The Political Structure: This type of organisation is described in terms of power rather than structure. It develops out of conflict and usually develops into two distinct sides. Hence, conflict pervades the whole organisation. This is very

often seen in government-sponsored bodies in the public sector, but is also becoming common in the private sector.

‘What characterises the organisation dominated by politics is a lack of any forms of order found in conventional organisations. In other words, the organisation is best described in terms of power, not structure, and that power is exercised in ways not legitimate in conventional organisations. Thus, there is no preferred method of coordination, no single dominant part of the organisation, no clear type of decentralisation. Everything depends on the fluidity of informal power, marshalled to win individual issues.’ Mintzberg, H., (1989: 241).

The Canadian socialised health care system appears to have elements of several of these configurations; by the nature of the majority of their employees, hospitals will automatically fit into the ‘professional’ structure. In more recent times the machine and the political structures are seeping into health care. Mintzberg (1989) finds this a dysfunctional progression, as he believes that imposing external controls on professionals will stifle the competent professional and will not improve the weak or incompetent professional. He adds that it has been popular wisdom for the last century to push everything towards machine bureaucracy, as it was seen as ‘the best way’. Mintzberg predicts that this is a mistake, as not all organisations are capable of machine bureaucracy. This is especially true of the health care organisation such as a hospital. With mainly professions, the idea of streamlining them into task performers seems ludicrous. Health care professionals are qualified to perform many tasks but also are capable of critical thinking and decision-making. Thus the idea of treating medical professionals as a commodity will naturally cause them to balk at the system.

Trust, Power and Knowledge

Trust is attributable to all relationships within and between social groups (Hardin, 2002). McKnight and Chervany (1996) define trust as containing such elements as:

- The willingness of one party (trustor) to rely on the actions of another party (trustee);

- Reasonable expectation (confidence) of the trustor that the trustee will behave in a way beneficial to the trustor;
- Risk of harm to the trustor if the trustee will not behave accordingly;
- The absence of the trustor's enforcement or control over actions performed by the trustee.

People may work together and achieve success through trust by relying on each individual's contribution (Dirks & Ferrin, 2001). Shneiderman (2000) reminds us that trust has positive effects on attitudes, perceptions, behaviours and performance outcomes within organisational settings. Consequently, a lack of trust can have negative effects. He goes further, saying that rational reflection leads us to reject placing trust in technology. This concept fits in with the data presented here. While nurses in the PICU are located in a highly advanced technological environment, they have an educated scepticism about the ability of technology to protect their patients, and thus this expectation is transferred to colleagues working with technology. Luhmann (1979), Barber (1983), and Giddens (1984) acknowledge the relationship between trust, control, confidence, risk, meaning and power. Luhmann (1979) argues that both familiarity and trust are linked to one another with trust presupposing familiarity. Familiarity is based on experience and, similarly to trust; familiarity helps to reduce the possibilities of the occurrence of unanticipated events because people are familiar with each other's expertise and skill levels (Luhmann 1979). This is consistent with the data collected in the interviews where nurses describe both trust and familiarity interchangeably. In further support of this notion Misztal (1996) combines all concepts of trust. She points out three things that trust does in the lives of people:

- It makes social life predictable.
- It creates a sense of community.
- It makes it easier for people to work together.

In order to discuss human relationships within a cultural context power and knowledge need to be considered. Many different types of power have been described. In their classic study, social psychologists French & Raven (1959)

developed a schema of the sources of power by which one can analyse how power-plays work in a specific relationship (see *Table 2*).

Table 2: French and Raven Sources of Power (1959)

Positional Power

Also called "Legitimate Power", it refers to the power of an individual. Legitimate Power is formal authority delegated to the holder of the position.

Referent Power

Referent Power means the power or ability of individuals to attract others and build loyalty.

Expert Power

Expert Power is an individual's power deriving from the skills or expertise of the person and the organisation's needs for those skills and expertise.

Reward Power

Reward Power depends upon the ability of the power wielder to confer valued material rewards. It refers to the degree to which the individual can give others a reward of some kind such as benefits, time off, desired gifts, promotions or increases in pay or responsibility

Coercive Power

Coercive Power means the application of negative influences onto employees. Coercive Power tends to be the most obvious but least effective form of power as it builds resentment and resistance within the targets of Coercive Power.

Max Weber (1864–1920) describes a typology of power. He describes power as three types of authority: *charismatic, legal/rational and traditional*. Carspecken (1996) further expands this typology of power.

Carspecken's Typology of Interactive Power (1996)

- *Normative power*: The sub-ordinate² tends to admire the social position of the super-ordinate³ because of cultural norms. In this relationship the sub-ordinate consents to the power imbalance because of the social norms of class/status difference.
- *Coercive power*: The sub-ordinate acts to avoid sanctions imposed by the super-ordinate. This type of power occurs without the consent of the sub-ordinate in the relationship.
- *Interactively established contacts*: The sub-ordinate tends to be motivated by the potential return of favours or rewards from the super-ordinate.
- *Charm*: The sub-ordinate acts out of loyalty to the super-ordinate, because of the super-ordinate's personality.

The types of power described above are considered interactive power. Thus, as a discipline that deals exclusively with the public and with other health care professions, the understanding of power and power imbalances are fundamental to nurses' function. Power is central to the theory of truth in critical epistemology, which is based in common forms of communication (Carspecken, 1996).

The relation between power and knowledge is of great importance. Different critical theorists take different positions on the relationship between power and knowledge. The poststructuralists following Foucault (1977) describe the interrelationships between power and knowledge, disclosing the manner in which power constitutes knowledge and knowledge constitutes power. Foucault highlighted the essential interrelatedness of power and knowledge in his concept of power/knowledge. Every action and every historical event is seen by Foucault as an exercise in the exchange of power. He describes the flow of power in different situations and with relevance to different aspects of human life. Structure organises and broadens the web of power (Foucault, 1982). Foucault believed that knowledge is always a form of power and that knowledge can be gained from power, producing it, not preventing it. Through

² Sub-ordinate is a person placed in or occupying a lower class, rank, or position: INFERIOR <a *subordinate* officer> submissive to or controlled by authority.

³ Super-ordinate is a person of higher rank, status, or value.

observation, new knowledge is produced. In his view, knowledge is forever connected to power.

Knowledge linked to power not only assumes the authority of 'the truth' but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, 'becomes true.' Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practice. Thus; *'There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations.'* Foucault, (1977: 27).

However, Carspecken (1996) views power and knowledge as analytically distinct in the following ways:

- Knowledge can overcome power. For example, in the PICU the gaining of expert status for the nurse may bring with it certain privileges that are not accessible to the junior nurse. (For example: being chosen to care for the more complex and interesting patients.)
- Power can be 'measured' in terms of the extent to which efforts are made to block knowledge.
- Critical theory seeks to break down the barriers that power creates, or equalises it by pitting knowledge against power (Carspecken, 1996).

The Feminist Perspective: Throughout this project the opinions and lived experiences of women are present, since the majority of nurses in PICU are female. Feminist thought views gender as the principle that shapes the conditions of individual lives (Fox-Keller, 1985). Lather (1991) believed this type of research would end women's unequal social position. The aim of feminist research is to generate an accurate account of women's lives and to communicate new knowledge in order to change the conditions in which women live. Feminist theory can complement critical ethnography. The discipline of nursing has been influenced by both critical and feminist theories that explore gender, class and social relations (Browne, 2000; Donnelly, 2004; Guruge & Khanlou, 2004; Racine, 2003; and Kirkham & Anderson,

2002). Carspecken (1996) notes that critical epistemology has evolved as a way to understand the relationship between power and truth. A critical epistemology perspective is an understanding of the relationship among power, thought, and truth claims. Critical inquiry challenges the status quo and the dominant powers in society and, thus, offers new ways for nurses to address health care issues and practice (Allen, 1985). The feminist perspective supports the analysis of gender, race, and class relations and examines knowledge from different social and political locations. Together these theories provide a theoretical lens for us to examine the power imbalances embedded in a female dominated profession such as nursing. Within nursing research, a feminist perspective is usually used to challenge discrimination within the health care system. It is not usually used to discuss nursing itself (Im, 2010). However, it has a profound effect on nurses and on nursing practice. Feminism helped change nurses from obedient daughters in nurse-physician relationships to often-outspoken women (and sometimes men) who valued autonomy, professionalism, and caring (Ettinger, 2009).

Malka (2007), terms Florence Nightingale's era as 'Nightingale's Victorian paradigm'. She points out that '*this paradigm dominated the late nineteenth century into the twentieth century*' (2007: 5). In the 1940s and 1950s, most nurses attended hospital diploma schools where they showed proper deference to physicians and submitted to tight control of their lives by nursing superintendents (Malka, 2007). Between 1965 and 1985 nursing changed forever: Bachelor's and Associate's degree programs in nursing replaced hospital diploma schools, and graduates demanded greater autonomy and worked outside the hospital, sometimes as nurse specialists who performed functions previously associated with physicians. In addition, some nurses explicitly connected women's subordination with nurses' subordination. Even as feminism influenced nursing, many feminists saw nurses as perpetuating traditional notions of womanhood and patriarchal relationships. However, Carol Gilligan's *In a Different Voice* (1982) offered nurses a different form of feminism. Gilligan concentrated on the traditional female values of caring and nurturing. In the 1980s and 1990s, nurses integrated feminist methods and ideas into nursing school curricula (Reverby, 1987). They also took on increasingly autonomous roles and dramatically changed the hierarchical nurse-doctor relationship. Thus, the changes in

nursing thought have mimicked the changes in how women have viewed themselves over the last 100 years.

Statement of the Problem

It is evident from this review of the literature that there is a significant body of research on the nursing shortage. In the past thirty years a large body of knowledge has been produced concerning retention and recruitment of nurses. Much of the literature is concerned with adult intensive care units and the issues involved in retaining qualified staff for adult areas. Children make up approximately twenty percent of our population; in general they do not suffer mortality and morbidity of diseases to the same degree as that of the aging adult population. However, while paediatrics represents a much smaller patient population, it is nonetheless significant. Care of the paediatric population is the basis for the health of our next generation. A gap exists in nursing knowledge pertaining to the environment of the PICU and the contribution of culture within a unit in the formation of a nurse's intention to leave or to stay at the bed-side of the critically ill child in intensive care (Foglia et al., 2010). In an effort to reduce this gap, this study explores the culture perspective of a PICU environment using the qualitative research approach of Critical Ethnography (CE). CE is an interpretative research methodology that allows us to look at the cultural aspects of a society, a group, or an organisation 'within their setting' and to understand and expose the meaning of the relationships in that environment; without meaning being imposed on them externally (Brewer, 2000). Denzin and Lincoln (2000) continue to explain that '*... by entering into firsthand interaction with people in their everyday lives, ethnographers can reach a better understanding of the beliefs, motivations and behaviours of their subjects than they can by using any other method.*' (2000: 470).

The next chapter will outline the research design, including the philosophical background and methodology of the study.

CHAPTER 3: METHODS

Introduction

Chapter 2 outlined the theoretical location of this project, situating the research problem and questions within the broader theoretical and empirical terrain. Chapter 3 illuminates the author's approach to researching the PICU environmental influences on nurses and their intentions to stay at or leave the bed-side of critically ill children. This chapter starts with a description of the research design and its philosophical basis. It describes the methods, including data collection, sampling and analysis within a critical ethnographic framework. The limitations of the methodology and the role of reflexivity in the whole research process are discussed. Finally, the ethics of this study are examined.

Research Design

Critical Ethnography was the research design chosen for this work, however before coming to this decision the author considered several qualitative designs. Originally, a qualitative design with constructivist philosophical underpinning was felt to be appropriate for this study. Constructivists fall under the umbrella of Interpretivism (Williamson, 2005). Qualitative research from an interpretivist point of view seeks to understand the meanings in human action (Schwandt, 2003). Constructivists allow the researcher to investigate constructions or meanings about broad concepts such as cultural values, or more specific issues or ideas (Williamson, 2005). There are two major constructivist approaches -- one focusing on individual, personal constructions and the other on shared meanings that could be said to reflect social constructions (Berger & Luckman, 1967). Constructivism focuses on how researchers *constitute* theories when describing them (Mir & Watson, 2001). However, in this study the researcher wanted to describe the human impact on power and knowledge in the PICU. Therefore critical methodologies' were considered.

Critical methodologies are aligned with the post-Enlightenment philosophical tradition of situating research in its social context to consider how knowledge is shaped by the values of human agents and communities. It also considers how power differences shape knowledge and how knowledge supports the democratising of relationships (Belsey, 1983). That is, this approach does not separate theory and

method, interpretation and data, subjective and objective, and ethics and science. Critical ethnography prefers to see these constructs as interconnected, making mutual contributions to knowledge (Marcus & Fisher, 1986). Kwan and Tsang (2001), note that critical realism represents an important point of epistemological departure from mainstream realism, and that it has the potential to inform research.

There are important differences between constructivism and critical realism. Critical realism contests some of the default assumptions of empiricism and realism, which treat social systems as closed systems; it is still based on the inherent order of things that is graspable by research (Mir et al., 2001). If one assumes a critical realist position on ontology we seek to go beyond *reconstructing* a culture. We seek to understand the relationships between culture and social structures (Georgiou & Carspecken 2002). *'Knowledge, in critical social theory, is in addition understood to be always a social product formed within a social relationship involving power. Thus, standards of truth can only be formulated if they take the power relations inherent to research acts into account.'* (2002:689). This is an important factor when considering PICU nurses and their environment. That is, in order to understand the influences on these nurses one must understand their reality. This may not be the researchers' reality or her knowledge of reality; Carspecken (1999) notes that reality is distinct from knowledge about reality.

Action research was also considered. This research methodology is participatory and self-evaluative, and the author has to continually evaluate with the objective of improving the environment or the situation for the staff. However, as this study is thesis-generating, action research would not be appropriate at this time; although it may be a very effective research methodology for subsequent research in this area.

A quantitative design was not considered for this study. Quantitative methods are generally deductive and are designed to test theory. This approach would not have allowed a full, in-depth exploration of nurses' individual and unique experiences, which was required to fulfil the research aims. The research topic was not suitable for quantitative methodologies or methods such as surveys either by questionnaire or interviews. Surveys try to measure facts, attitudes, knowledge and behaviour in a

structured way (Bowling, 2002). The behaviour and/or knowledge being sought here is not sufficiently specific to be structured.

Wainwright et al. (2002), remark that: *'The reluctance of psychology to engage fully with the subjective life of the worker has created a lacuna in the pathway from work characteristics to the physiological changes associated with stress response.'* (2002: 81). Involving workers in the research rather than treating them as passive objects of study provides a theoretical framework which will be sufficiently broad to encompass the complex sociology of the individual (Wainwright et al., 2002).

Critical ethnography (CE) became the methodology of choice as it allows a more critical analysis of the PICU environment by using the power imbalance within all social constructs (as suggested by critical social theory) in order to understand these environmental influences on staff. CE includes in-depth semi-structured interviews with currently and previously employed nurses in PICU, and unobtrusive observation recorded in field notes. The advantages of semi-structured interviews are that they allow all participants to be asked the same questions within a flexible framework. The open nature of the questions encourages depth and vitality and allows new concepts to emerge (Dearnley, 2005). The researcher can probe fully for responses, and clarify ambiguities; complex topics can be explored; and inconsistencies and misinterpretations can be checked (Bowling, 2001). Observation is an important adjunct to studies that rely mainly on interviewing as a data collection technique. Observational methods note body language and other behavioural cues that lend meaning to the words of the person being interviewed (Angrosino, 2005).

Observation of the physical settings, such as the PICU, can enlighten the interpretation of the participant's world and assist in making sense of the social system. Focus groups were considered for the data collection from PICU nurses. Although focus groups are a useful tool for understanding people's attitudes and opinions, they were not used because they are incompatible with gaining an in-depth understanding of participants' experiences, as participants often feel uncomfortable disclosing sensitive feelings and experiences in a group setting (Webb & Kevern, 2001).

Ethnography, Critical Social Theory and Critical Ethnography

Ethnographic research may describe the culture but it is not intended to assist in the interpretation of that culture's influences. Madeleine Leininger, an anthropologist and nurse (Leininger, 1978), and Pamela Brink (Brink, 1979), were the first to advocate critical ethnography (CE) as a suitable methodology for understanding health related issues. CE is based on both critical social theory (CST) and ethnography: CST provides the theoretical foundation for CE and ethnography provides its methodological origins. CST was developed in an era of intellectual revolution, which included changing ideas about power (Madison, 2005). CST questions historical power structures and advocates for equity for marginalised groups (Giroux, 2004). Giarelli (1992) writes: '*Critical theory is, at its center, an effort to join empirical investigation, the task of interpretation, and a critique of this reality*' (1992: 3). Browne (2000), one of the leading theorists on CST, describes four central tenets of CST to be considered in health care research. First, CST is based on an understanding that no value-neutral or foundational knowledge can be known outside the human dimension. That is, human beings, having developed foundational knowledge, have already placed values on it. Second, all social order involves some form of domination and power. Browne suggests that in all social structures constructed by humans there is built-in power imbalance. Understanding these power dynamics is essential to appreciating the complexities of health care environments. Third, knowledge is mediated by power relationships. That is, the process through which knowledge is constructed is influenced by the unequal power relations within human societies (Smith, 1990). Finally, language is the centre for the creation of knowledge. Language is the basis of our communication, and thus the driving force behind the creation and dissemination of knowledge.

CST is a useful lens through which to look at issues of equity in healthcare because it draws attention to power imbalances and oppression within the environment (Basu, 2008). Cultivating the nurse's voice is one strategy for realising some of the goals of CST (Jenkins, 2006; Lensmire, 1998; Polman & Pea, 2001).

Ethnography is qualitative inquiry that provides a means of exploring a cultural group (Morse & Richards, 2002); '*a picture of the 'way of life' of some identifiable*

group of people' Wolcott, (1999: 160). A realistic, apolitical, and interpretive description of the culture being studied (Hammersley & Atkinson, 2001). Spradley (1979) and Polit & Hungler (1999) note that ethnography is about learning from people, the better to understand their world as they view it. Morse and Richards (2002) suggest that culture is the lens through which people view their world.

The view of the ethnographer (presumed to be an *outsider*), is considered to be the *etic* perspective. The *insider's* view is described as the *emic* perspective. An important component of a culture is *tacit* knowledge. This is '*information about the culture that is so deeply embedded in cultural experiences that members do not talk about it or may not even be consciously aware of it*' Polit & Hungler, (1999: 245). It is the goal of the ethnographer to gain an understanding of the *emic* perspective and to reveal *tacit* knowledge (Goodwin, Pope, Mort & Smith, 2003; Platzer & James, 1997; Polit & Hungler, 1999). According to Madison (2005) '*... theory is used in ethnography as an interpretive or analytical method, to interpret or illuminate a social phenomenon*' (2005:12). In this study this knowledge will reveal the unseen influences on nurses' intentions to stay in or leave bed-side nursing in PICU. Ethnography has evolved to become critical ethnography (CE). Thus, while ethnography represents an apolitical interpretation, CE is embedded with values. Thomas (1993a) believes that CE is a style of analysis rooted in conventional ethnography (Thomas, 1993b). CE focuses on raising consciousness and aiding emancipatory goals to effect social change (Polit & Beck, 2004). It extends the boundaries of ethnography (Roberts & Taylor, 2002; Seal, 1999; Street, 1992; Taylor, Kermode & Roberts, 2007). Power is a fundamental component in CE. Critical social theory encourages the researcher to use a power lens to view the world; that is, to see power imbalances in all human social constructs (Browne, 2000). Investigating the environmental influence on nurses in PICU from a critical perspective will allow us to consider the power imbalances built into both nursing and the culture of PICU.

Critical Ethnography as Methodology

Research Framework

This study explores the environment in a PICU using the qualitative research approach of CE. CE as an interpretative research methodology looks at the cultural aspects of a society, a group, or an organisation 'within their setting' to understand and expose the meaning of the relationships of their world, without meaning being imposed on them externally (Brewer, 2000). Denzin & Lincoln (2000) continue to explain that '*... by entering into firsthand interaction with people in their everyday lives, ethnographers can reach a better understanding of the beliefs, motivations and behaviours of their subjects than they can by using any other method*' (2000: 470). The author believes that power can be overcome by knowledge, and that knowledge is used to wield power. The fact that the researcher is a PICU nurse co-ordinator, and considered an expert in the field, has led to the development of a variety of assumptions (see *Appendix A*). These were developed at the beginning of this research process and were revisited throughout the study. They have influenced the design and implementation of this study; specifically, the researchers view of power.

It is fundamental to CE that the researcher understands the features embedded in CE:

1. CE is considered the 'performance' of critical theory (Madison, 2005).
2. CE is '*a methodological framework to document, analyze and act on the discriminatory practices.*' Seiler, (2001:1003).
3. CE is situating research in its social context to consider how knowledge is shaped by the values of human agents and communities as implicated in power differences (Atkinson, Coffey, Delamont, Lofland, J. & Lofland, L., 2001).
4. CE supports positioning the researcher as an *insider* to investigate his/her own environment (Carspecken, 1996).
5. CE emphasises in-depth investigation of participants' lives from an *emic* (*insider*) perspective. CE enables the researcher to explore a particular topic or shared experience from a group's *emic* perspective (Morse & Richards, 2002).
6. CE is often used to study sub-groups within a culture or to study institutions (Morse & Richards, 2002).

7. CE acknowledges the researcher's own biases, or more appropriately termed, values and value-laden assumptions (Madison, 2005). This acknowledgement encourages a more in-depth critical analysis of a single environment or culture.
8. The purpose of CE is to create a detailed and nuanced account of a particular setting, attending to enactments of power and privilege, points of conflict, and discourses as they are enacted in everyday encounters (Carspecken, 1996).

This also supports the reasoning for using Carspecken's framework for this project as it is the methodology that is most closely aligned with the researchers' perceptions of power and knowledge. CE encourages researchers to identify their own biases before embarking on a CE research project; once declared, this information can be used by an independent party to assess the collected data for undue bias (Carspecken, 1996).

To conduct this research project, Carspecken's (1996) five stages for critical qualitative research are followed:

Table 3: Carspecken's Five Stages (1996)

| | |
|--------------------|---|
| Stage One | <i>Compiling the primary record</i> 1) Unobtrusive observation 2) Intensives notes on research site. 3) Monological* information collection |
| Stage Two | <i>Preliminary reconstructive analysis</i> 1) Analysis of primary record 2) Reconstruction of data |
| Stage Three | <i>Dialogical data generation</i> 1) Converse with subjects through interviews 2) Democratise the process |
| Stage Four | <i>Describing system relations</i> 1) Examine relationships between various environmental influences on the site of interest. |
| Stage Five | <i>System relations as explained by findings</i> 1) Explain findings 2) Suggest reasons for experience |

| | |
|--|---|
| | 3) Suggestion reasons for cultural forms that have been reconstructed |
|--|---|

**Monological dialogue refers to the researcher speaking alone; that is, he/she does not involve the people under study in dialogue as yet, allowing a purely third-person observation of them (Carspecken, 1996).*

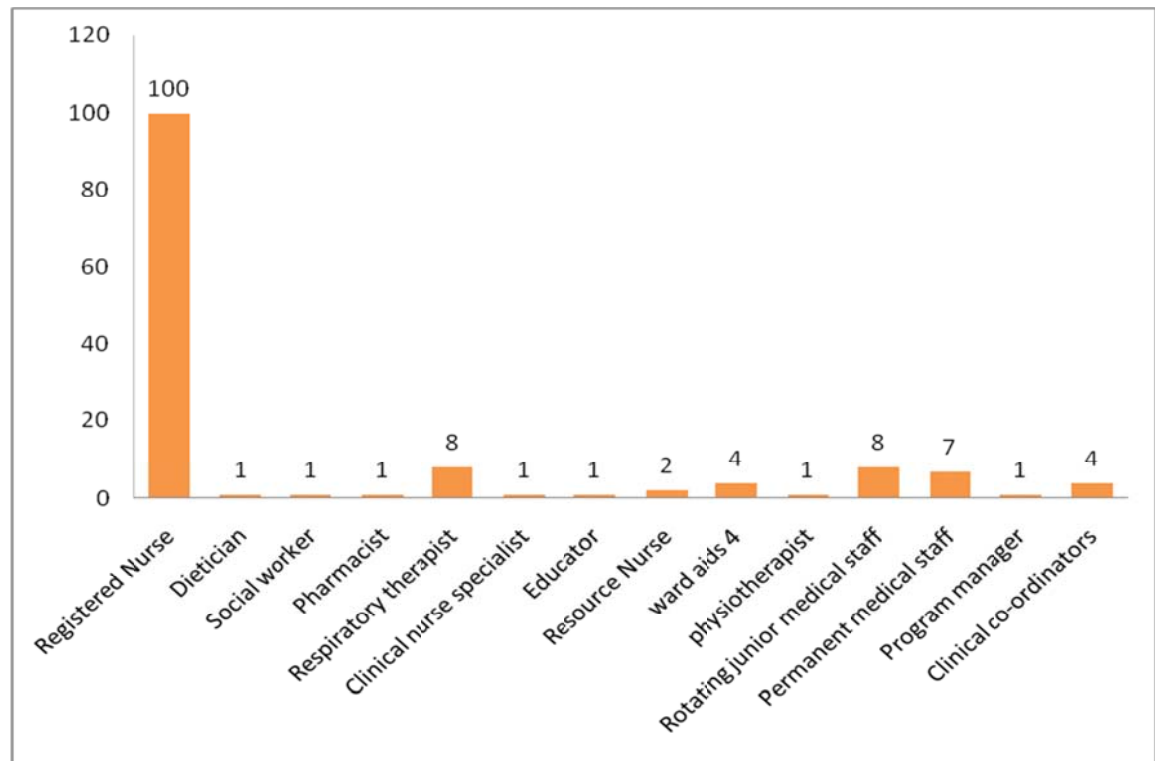
CE was the methodology of choice for investigating influences on nurses, taking the underlying culture into account.

Population and Sample

Setting: The 22-bed unit to be studied is located in Western Canada. The nursing management group/ team consist of: 4 clinical coordinators, 1 manager, 1 educator, 1 clinical nurse specialist and 2 resource nurses. Internal management-team data (*personal correspondence*) in this unit shows that there has been an approximate 20% nurse attrition rate per annum for the last two years.

Participants: Participants were nursing staff working in the PICU where the researcher is employed (please refer to section on *Minimising Biases Page 38*). Nurses in the PICU are approximately 80% of the workforce; they are a significant voice to consider in the cultural climate of PICU. Approximately one-third of the nursing population of this PICU were interviewed ($N=31$). The ‘casual employee participants’ are referred to as participants 1a to 5a. These casual nurses work in the ICU at least once a week. The remaining participants are referred to as participants 1 to 26. They ranged in age from late twenties to sixty, with a minimum of two years’ experience in the PICU and a maximum of 35 years. This nursing population included 3% males, which is an accurate reflection of the male nursing population in this PICU.

Figure 1: PICU Professional Distribution



Inclusion/Exclusion Criteria: Participants are registered nurses currently working in the identified PICU in Western Canada. The researcher avoided restricting participants according to years of work experience so as not to lose valuable information by not interviewing those who are just starting out on their PIC careers. Sample size was determined when sufficient context-rich material had been collected and when *data saturation* occurred (Polit & Beck, 2004). According to Van Belle (2002) a minimum of 10 interviews is required. However, more than 30 participants volunteered to be interviewed. Five of these participants were staff who had worked in PICU on a full time basis and now work in PICU on only a casual basis. It was deemed appropriate to group these five participants in a separate group, as their unique experience might be lost if they were grouped with the present employees. A component of 26 presently employed staff were interviewed, giving a total of 31 interviews.

Sampling and Recruitment Strategy: According to Patton (1990) purposive sampling is appropriate if one selects subjects based on particular characteristics. In this case a stratified purposeful sample (Patton, 1990) was chosen, as it illustrates the

characteristics of the particular subgroup of interest (a PICU in Western Canada). This facilitated comparisons among participant responses (Patton 1990). Participants were informed of the study through discussion at the PICU management meeting, announcements at PICU nursing education days, posting and the distribution of a '*Participant Information Sheet*' and an '*Invitation to Participate sheet*' at the PICU front desk and coffee room, and email distribution of a '*Participant Information Sheet*' and the '*Invitation to Participate sheet*' (see *Appendices B and C*). All staff were encouraged to contact the researcher if they had further questions. Once the researcher was contacted by a potential participant, written consent was obtained and confidentiality was discussed (see *Appendix D*). A date and time was set for each interview. Consent and confidentiality were reviewed at the beginning of each interview.

The project had the support of the PICU management. They allowed the researcher to use the ICU facilities, including computers. The unit volunteered to donate nursing time to this project. That is, the resource nurse covered the patient in the unit while the participating nurse was being interviewed, so the research process did not impact on the functioning of the unit. One change the author made to this research was to alter the title in order to use the term most familiar to the participants. She had originally used the term 'Critical Care' rather than 'Intensive Care'; as she spoke with staff it became apparent that 'Intensive Care' was their more common, familiar term of reference.

An Interview Guide was drawn up to address the aims and objectives of this research based on Patton's (2002) model of interview guides (see *Appendices E & F*). A small pilot study was undertaken with three currently employed PICU nurses from the management team in order to test the data collection methods and refine the interview guides. The pilot was particularly useful for testing the method of conducting, audio-recording and transcribing semi-structured interviews (Dearnley, 2005). It was recommended by the participants to include the demographic component of the interview as oral questions rather than as a paper version. The participants felt this would help to put them at ease and draw them into the interview (see *Appendix F*). This suggestion was incorporated into the final interview guide.

These interviews also revealed a tendency for participants to focus their responses on why they did not work there any more, rather than discussing what it is about the PICU that would encourage them to stay in the unit. To avoid this bias the researcher decided to interview staff who still work in the PICU in staff-nurse capacity, as the focus of this work is also to understand the influences that encourage nurses to stay in PICU.

The length of the interviews ranged from 24 minutes to 60 minutes, with an average of 45 minutes. Each interview was followed by an unrecorded discussion of issues raised in the interview and/or issues concerning the PICU in general. The researcher did not record this portion of the interviews, in order to ensure that participants could openly discuss any issues brought out by the interview. The researcher did record her own observations and reflections on each interview and the after-discussion in field notes following each interview, and also recorded her reflections during transcribing and analysis. The field notes formed part of the primary data. The interviews were transcribed, and the researcher listened to the interviews many times when editing the transcripts. This was a useful way to begin to understand the data, as it took an extensive period of time to edit the transcriptions for accuracy. A colleague checked a random sample of the transcripts for accuracy. That is, one of the researchers' colleagues' agreed to listen to a recording of one of the interviews and then check it against the transcript. The interview was picked randomly from the 31 interviews recorded. The transcripts proved to be accurate and few or no corrections were needed.

Observation: A staple of CE research data collection is observation (Madison, 2005). To compile the primary record, the researcher commenced documenting everyday working of PICU (Morse & Field, 1995; Mulhall, 2003). *Unobstructive observation* was employed for this stage of the project. This type of observation is carried out without the explicit awareness and agreement of the subjects being observed (Carspecken, 1996), thus the researcher's presence does not affect the behaviour of those being observed (Mays & Pope, 1995). However, the purpose of the researchers' presence was mentioned at the weekly staffing meeting and documented in the unit communication book, and all staff received a copy of the *Participant*

Information Sheet via email (See Appendix B). No staff members were identified during this period. The subjects in this observational period are identified by profession only. Patients and families were given a *Family Information Sheet* so they were aware who the researcher was and why she was in the unit (see Appendix G).

Auditability, credibility, fittingness and confirmability address the four issues of rigour: consistency, neutrality, truth-value, and applicability (Szabo & Strang, 1997). Auditability was achieved through recording the investigative process, analysis and emerging theories in the form of detailed notes. These notes became part of the record of the researcher's qualitative thinking and inductive work (Morse & Richards, 2002). The purpose of this observation is to take the reader into the setting being observed (Patton, 2002). This data is descriptive and accurate. The objective of data collection was to obtain information from a variety of sources and perspectives in order to provide a critical picture of unit culture and environment.

Data Analysis Plan

Data collection and analysis occurred concurrently with observations and interviews, becoming more focused over time (Morse & Richards, 2002). Data collection continued until sufficient in-depth data had been obtained, and themes depicting the culture in this setting are well developed. Carspecken's (1996) five stages for critical qualitative research were followed. A brief review of the five stages follows:

Stage One - Compiling the primary record: Observation: A staple of CE research data collection is observation (Madison 2002). To compile the primary record, the researcher documented the everyday workings of the PICU (Morse & Field, 1995; Mulhall, 2003). Stage one of Carspecken's framework includes unobtrusive observation. More than 20 hours of unobtrusive observation were conducted by the researcher in the PICU. The researcher decided that the 'front desk' would be the most appropriate place to view the unit and most of the people coming and going from the unit. The 'front desk' is not at the front of PICU but is situated in the middle of the horseshoe shaped unit, thus acting as the hub of the unit. The researcher would spend one hour at a time in this area. Different times of the day were chosen in an effort to vary the observations. Also, the researcher documented her observations and

the conversations she heard verbatim. This produced intensive notes on the research site. Following this a 'monological dialogue' was conducted by the researcher. Carspecken recommends this monologue so as to deepen the researcher's understanding of the research site and identify the researcher's own notions and ideas early in the study, thus minimising researcher bias. Researcher bias is addressed by this method because it allows the researcher to openly identify his/her beliefs associated with the research site. The researcher developed a list of her own ideas or notions regarding PICU and the staff who work there (see *Appendix A*). *'An intensive set of notes is built up for the site of focus and a looser journal kept on observations and conversations made by frequenting the locale of the site. The information collected in this way is 'monological' in nature because the researcher "speaks" alone when writing the primary record. The researcher does not involve people under study in any penetrating dialogue but rather takes a purely third person position in relation to them: describing them from the perspective of an uninvolved observer.'* Carspecken, (1996:42).

The observations' were the first form of data collected. However, the interview question and guide was developed before the observations' were conducted. This stage was completed before any other stage of the research was conducted. The author believed it was important to do this so as to avoid the observational data unduly affecting the types of questions the researcher asked in the interviews.

Stage Two - Preliminary reconstructive analysis: One of the most important elements at this stage is reconstructive analysis; that is, making explicit those implicit structural features and their implications on the actors, identifying values and power balances that are a part of the culture but are unarticulated by the actors themselves. The researcher reconstructed a written document into a Story of PICU environment (Carspecken, 1996) (see *Appendix I*). Stage Two moves the researcher to the analysis. Analysis of the primary record is conducted by deconstructing the primary record; that is, breaking down the rich description gathered as the primary record, again using Carspecken's framework to analyse and deconstruct and eventually reconstruct the primary record by suggesting possible subjective, objective and normative evaluative claims (see *Table 4*). This allowed the researcher to consider interactions and observations, and diagnose biases or power imbalances. Carspecken

(1996) suggests that this type of analysis will aid in maintaining the three ontological categories of validity: that is, objective, subjective and normative/evaluative.

Carspecken reminds us here that in critical social research we translate truth claims into validity claims with the understanding that any truth claim is culturally bound.

Table 4: Sample of Reconstruction Analysis of the Primary Record

| |
|---|
| <p>April 8th: 15:30 (Senior ICU RN) - Critical care patient to return to operating room for chest closure. Operating room staff arrive and anaesthesiologist asks nurse #1 if blood is on hold for patient critical care nurse #1 asks unit care to check the blood bank if blood is on hold for patient. Operating room staff takes patient into the operating room for surgery.</p> <p>Nurse #1 return to the front desk to ask the unit clerk to have the bedside cleaned and ascertain how the blood bank responded. Unit clerk proceeded to call the cleaning staff and then said: “They said they did not know if there was blood on hold but they were put on hold now”</p> <p>Observer Comment (OC) – Nurse seems irritated by an answer she seems to find ridiculous, she appears to be unaware of the observer</p> <p>Possible subject of claims <u>Foregrounded, immediate</u> “That unit clerk is an idiot”, “that girl is not very bright”, “how could you not understand”</p> <p><u>Less foregrounded, less immediate</u> “I am more intelligent than you” “I know how to do my job”</p> <p>Possible objective claims <u>Quite foregrounded, quite immediate</u> “Did you understand my question?”</p> <p><u>Highly backgrounded, remote, taken for granted</u> “You are not a nurse” “you have very little educational”</p> <p>Possible normative-evaluative claims <u>Quite foregrounded, quite immediate</u> “You need to understand medical terms”</p> <p><u>Less foregrounded, unless immediate</u> “You need better training”</p> <p><u>Background, Remote</u> “You’re not good enough to work”</p> |
|---|

Stage Three - Dialogical data generation: This stage is the interviews stage. The researcher has decided on her research question before starting the preceding stages so as to avoid influencing the interviews by the data collected during the observation period. The specific details about reactions, behaviours or events occurring during the interview were recorded. This interpretive information aided in the analysis of the interview content (Carspecken, 1996). Validation of the findings was sought by presenting ideas from previous interviews to new participants. This helped democratise the process (Carspecken, 1996). The interviews were audio-recorded. Field notes were kept to enhance the recorded information with impressions and observations that the researcher makes about the interview process and content.

In order to challenge, illuminate or verify the findings, members of the research committee who have expertise in nursing research and/or the subject content provided consultation and advice throughout the research process. National and international experts were contacted to review different components of the research process and findings. Dr. Carspecken was contacted and confirmed the appropriateness of the approach and methodology. After these data were gathered, stage one and two were repeated, as the unobtrusive observation portion of an interview is done by recording body language etc. Carspecken recommends following his framework loosely: *'The five stages I recommend are not meant to be hard and fast, to be followed one after the other without ever returning to an earlier stage. Like many offers on qualitative research (LeCompte and Preson 1993 & Spradley, 1980), I strongly recommend a loosely cyclical use of the stages. One begins with the first three in a fairly sequential manner, but soon starts to repeat earlier steps in light of findings delivered through preliminary analysis'* Carspecken, (1996: 40).

Stage Four - Describing system relations: A full description of the documented relationships was developed and added to the database. *Confirmability* was addressed through consistency in the methodological approach to analysing the data, using *reflexivity*, being true to the research questions, using appropriate coding, and reporting of rich, descriptive narratives to support emerging cultural themes. Reflexivity is viewed as an essential component of rigour (Morse & Richards, 2002).

Fetterman (1998) suggested spending time reflecting upon one's biases and assumptions in order to prevent them from influencing the quality of the study.

Analysis begins with a process of data coding. Coding is a mixture of data reduction and data complication. It is generally used to break down data into simpler, general categories and it is used to expand the data in order to formulate new levels of interpretation (Coffey & Atkinson, 1996).

Computer software can be used to assist the coding process in qualitative research and it has certain advantages. Fielding and Lee (1998) argue that computer use in qualitative data analysis can facilitate data management. The researcher was assisted by use of *N-Vivo* for the study database. Fielding and Lee suggest that computer software can enhance the acceptability and credibility of qualitative research. However, a possible risk identified with the increasing use of computer assisted data analysis is convergence toward one dominant mode of analysis (Coffey & Atkinson, 1996). Morse (2006) notes that the computer does not do the analysis or build the theory, that this remains the domain of the researcher. As a new researcher, the author came to realise that using a computer software program to do coding was not going to enhance the learning experience. As Weitzman (2000) notes, learning data analysis methods cannot be substituted by the use of computer software. In other words, to understand how data analysis is performed one cannot use computer software alone. To take advantage of the software and enhance her learning the researcher chose to use *N-Vivo* initially to code her data and finally, close to the end of coding, switched to the more traditional manual coding method. This switch was made only when the final groupings/categories were identified using *N-Vivo*.

The in-depth experience gained by this mixed method allows this researcher to experiment with computer software in the future. Thorne (2008) suggests that a good coding scheme is one that steers the researcher toward gathering data into groups with similar properties. She also recommends that one should not be '*derailed by excessive precision in your early coding*' (2008: 145). This became a recurrent piece of advice during the researcher's early coding, which allowed her to truly see the data. Coding involved detailed annotation of each transcript and the identification of

themes or concepts. The concepts and the properties that define themes were highlighted in the text (see *Table 5 & Appendix J*) These were recorded and referenced by using *N-Vivo* with the final themes identified manually. This facilitated cross referencing and comparison of the data, which led to inferences on these themes and ideas.

In Stage Four the relationships among the environmental influences at the site of interest were examined. Primarily, themes were extracted from the data, giving evidence to support these themes from the primary data. The author speculated on why these themes exist and on the nature of the environmental influences that created such ideas. This stage is documented in Chapter 4.

Table 5: Themes

| Communication | FCC | Power imbalance | Patient/parents |
|---|----------------------------------|--|---|
| Geography | Time | Autonomy | Nurturer |
| Continuity | Sympathy Empathy | Paternalism | Maternalism |
| | Anxiety & Violence Or Abuse | Power imbalance <ul style="list-style-type: none"> • Med/nursing • Junior/senior • Med/families • Nurse/families | Ownership |
| | | Hierarchy | Possession |
| Manipulation | | Loyalty | Empathy |
| | | Self scheduling | Advocate |
| | | Leadership vs. Management Teams | Death |
| Skills/Ed | Vocation | Junior staff | Moral distress |
| Superstar status | Love my job | Trust issues | Advanced surgeries |
| Technology | Doing good | Teaching | Peer support |
| Spotlight caring for the most sick children | Sense of identity, Self advocate | Seniors always taking the most ill patient | Working with unqualified Staff/Lack of Ed for seniors |
| Satisfaction | It just happened | Eat their young | Change |
| Personality | What I always wanted | Co-workers | Floating |
| Challenge& Responsibility | Always different | | Nights |
| So specialized | Ambition Pride & Status | | Health & Age |

Stage Five - System relations as explained by findings: The main goal of CE research is to create narrative that describes a specific culture (Morse et al., 2002). The first step in the analysis is aimed at developing an understanding of the cultural setting through data collection. The second analytic step is to develop thick descriptions through the process of coding. A synthesis of Carspecken's (1996) framework was utilised in this phase. Data were organised into patterns, categories, and basic descriptive units. Data obtained from all sources were compared in order to generate and test explanations concerning the relationship between unit culture and nurses' intentions.

By being reflective, the researcher's *insider's* perspective benefits both the interview and the analysis processes, as the researcher can draw upon personal experiences and theoretical knowledge to generate insights.

Carspecken(1996) notes that the aim of data collection and analysis is to reach the point where the researcher develops a 'fit' for his/her findings; that is, the researcher will discover the matches between the very specific reconstructions developed over stages one to four with existing theories. This will entail an in-depth review of appropriate theories such as agency, job embeddedness, organisational frameworks, novice to expert, power, etc. The appropriate theories are matched to the data, creating an in-depth view of the culture and environment in question. This enabled the researcher to draw on all available knowledge in order to advance the ideals of CE and to challenge the status quo. This stage is documented in Chapter 5.

Limitations of the Methodology

This study consists of a single site for data collection. This site is the primary employer of the researcher. In some research traditions this may be seen as a limitation. However, the CE researcher is an *insider* investigating her own environment or one with which she becomes familiar. Extended time in one setting is needed to gain an understanding of these features (Madison 2002). Although certain features of PICUs are similar, in many aspects of environment and culture they will

be incomparably different. Therefore, only broad principles could be applied across sites and cultures. These broad principles can be identified at a single site once the *insider researcher* can identify individual cultural perspectives.

By documenting her self-critique and discussing her ongoing reflexivity concerns with her thesis committee members, content experts and colleagues, this researcher was able to create a 'check and balance' approach to data collection and analysis. Several limitations of ethnographic methodology have been identified. They include the limitations of the researcher themselves, limiting attributes of language, and morphing effect of context.

The Researcher as a limiting factor: Wolcott (1975) argues that doing ethnography is a human task with human limitations. These limitations arise largely from interactions with individuals and the skills of the researcher. Wilson (1983) identifies that there must be an inherent suspicion of the intent of the research by the subjects in a research site. Subjects may feel an obligation to provide behaviour that is appropriate or expected. The success of the research is dependent upon a special inter-personal relationship with the researcher. There may be present as an undercurrent a desire to be evaluated positively (*See section on Bias below*).

However, it is in this uniqueness of experience that the ethnographic text gains authority. The text is a personal narrative in a discursive space (Pratt 1986). Clifford (1986) argues that ethnographers systematically construct stories they believe to be true of themselves and others. The construction is not premeditated, but contingent and fleeting. Therefore, an ethnography must tolerate a degree of pluralism and ambiguity.

Consequences of insider status: An *insider* will have certain biases or assumptions that might influence the data collection and analysis. However, in order to evaluate the cultural issues within a unit, the theoretical framework supporting critical ethnography (critical social theory and ethnography) is an essential one as it is the best methodology for researching the area in question, and produces the sort of rich qualitative data needed to *interrogate these relationship* in-depth. These relationships can only be understood or highlighted by an *insider*. The only way to be

a true *insider* is to be steeped in the culture that is under study. Thus, under these circumstances a single site with a researcher with *insider* status is an appropriate choice for this type of research.

Critical ethnography positions the researcher as an *insider* to investigate his/her own environment (or one the researcher had been ensconced in for many months). The purpose of critical ethnography is to create a detailed and nuanced account of a particular setting, attending to enactments of power and privilege, points of conflict, and discourses as they are enacted in everyday encounters. Extended time in one setting is needed to gain an understanding of these features. Although certain features of PICUs are similar, in many ways they will be incomparably different. Therefore, only broad principles could be applied across sites and cultures. These broad principles can be identified at a single site once the '*insider* researcher' can filter out individual cultural perspectives.

This researcher had to consider what it was she was trying to understand. Critical ethnography acknowledges the researcher's own biases or, more appropriately termed, values and value-laden assumptions. This concept encourages a more in-depth critical analysis of a single environment or culture.

Disadvantages of 'Insider' Status: The presence of the researcher will influence what people do and say (Hawthorn effect).

Interviewees whom the researcher knows may avoid making statements or doing activities in the presence of the researcher which they think may invoke the researcher's disapproval. Skilled interviewing can check that potential concern, and the presence of these behaviours is also data, and that data will enter the analysis.

An *insider* will have certain biases and assumptions that might influence the data collection and analysis. Methods in which this can be reduced include:
The use of non-leading interview methods.

Having peer de-briefers who are not themselves *insiders* to the site (show them samples of observational data, interview data, coding, and analysis) and member checks.

Collection of data from people who can be expected to experience the site from diverse perspectives: other nurses, some physicians and some patients.

Including an analysis of the effects of *insider* status on the data that is created.

Advantages of 'Insider' Status: An advantage of insider status is an enhanced ability to understand implicit features of the cultural milieu: as an *insider* the researcher may be able to understand certain data more accurately and more perceptively than an *outsider* could.

There can be fewer distortions than if an unknown *outsider* is present and asking questions.

Sometimes it is possible to obtain data that the researcher did not collect directly - e.g. Diaries belonging to participants.

The other consideration with using a single site is whether one can gain sufficient data to make a statement about the environment at that site. However, this is not seen as an issue with this particular site, with the researcher's access to over 90 nurses and a significant amount of medical and allied health staff that interact with PCC on a daily bases. These other health care professionals could have been drawn upon as a resource if the data collection and analysis had led the researcher in that direction.

Recommendations made by Dr. Carspecken (via email) as ways in which the integrity of the research process is ensured, using a single site:

- Use of non-leading interview methods.
- Having peer de-briefers who are not themselves *insiders* to the site (show them samples of observational data, interview data, coding, and analysis) and member checks.
- Collection of data from people who can be expected to experience the site culture from diverse perspectives.

- Inclusion of an analysis of the effects of *insider* status on the data that is created.
- An enhanced ability to understand implicit features of the cultural milieu; as an *insider* the researcher may be able to see and grasp certain data more accurately and more perceptively than an *outsider* could.
- The presence of the researcher will influence what people do and say. There can be greater distortions when an unknown *outsider* is present and asking questions. On the other hand, people the researcher knows may avoid saying things to the researcher or doing things in the researcher's presence that they already think the researcher might disapprove of. However, skilled interviewing can check that potential problem, and the presence of these behaviours is data as well and that data will enter the analysis. This will add a new dimension to the data.

Language as a Boundary: Ethnography necessitates language as it is the tool through which data is gathered, and interpretations about that data are communicated. Wilson (1983) proposes that language is a limiting factor in ethnographic research. Language is limiting in two ways; firstly in that there are concepts embedded in any language, and secondly in the rhetorical nature of language.

The first way in which language is limiting is one must have a word to describe, understand and communicate concepts and ideas. The strength of ones' understanding depends upon the right words existing and the intended meaning being attributed to those words by other individuals. Van Maanen (1982) argues that this limitation can be overcome if the participant observed acquires knowledge of the language spoken in the setting. As an *insider* the researcher was very familiar with the language and the type of work conducted in the research site.

Ethnography relies upon the narrative text. Since the Enlightenment study has been separated between rhetorical language and science. Where science came to be seen as a representation of reason, logic, methods and evidence, rhetoric was seen as a tool of arguments and persuasion that used the methods of opinion and ornamentation. However, Czarniawska-Joerges (1995) suggests that everyday wisdom is expressed in narrative knowledge. Coffey & Atkinson (1996) argue that ethnographic texts privilege the voice of the author's accounts and experience over other members of the culture, and may give visibility to dominating groups in that culture. The researcher was very aware of this potential limitation and relies heavily on

reflectivity and discussions with her supervisors to ensure her voice was not the dominant voice in the story of PICU. Coffey et al. (1996) identify the use of “thick description” by the ethnographic researcher avoid this limitation.

The Morphing Effect of Context: The environment in which the study is located is continuously shifting. This is restricting in two ways, externally and internally to the study. Firstly from an external viewpoint a snapshot of the organization at a place in history over a period of time is only possible (Pratt 1986). Cultures are not stationary to be captured in a moment of time for analysis. There is no one moment of absolute representation (Clifford 1986). Any ethnography can only be an historical inscription of relationships over time.

Secondly the site itself is constantly morphing with competing interests and representations. Wilson (1983) suggests that because of this it is difficult to then get a picture of the complete distribution of attitudes in a large organization. Wilson (1983) goes on to say that ethnographic techniques can gather data about human behaviour that cannot be obtained using other methodologies.

How the study design manages the necessity of minimising biases: As qualitative interpretative study this research is inherently biased by the fact that the researcher has certain values and opinions that are brought to the research. Critical ethnography embraces this idea and encourages the declaration of the research bias early in the process (Carspecken, 1996). This allowed awareness of the researcher’s own bias and how these biases might influence the research. Morse (2006) argues that bias is essential if good qualitative inquiry is to be conducted.

There was the potential for interviewer bias and participants’ deliberate social desirability bias. Having identified the researcher’s own biases she tried to reduce them to a minimum by acting in a neutral, non-judgmental manner (Bowling, 2001). But as an experienced PICU nurse, she naturally responded with understanding and encouragement in a face-to-face encounter with participants. The researcher was not able to change her persona for the interviews and being an *insider* there was a certain expectation from the interviewees that she would understand the nuances of this

particular PICU. This may have reflected the researcher's own cultural and professional values and led participants to respond in a certain way. It is difficult to assess the level of influence this may have had. However, she believes that her *insider* status, which suggested a level of trust (Carspecken, 1996), offered a unique opportunity for these nurses to discuss their profession honestly and with passion. Also, through the method of interviewing employed by this research project it was not possible to know how much of the participants' responses were affected by mood bias. All the other emotional effects of caring could also affect how participants described their experience.

Recall Bias: There was the potential for recall bias in which participants may have had selective memories in recalling events, experience and behaviour. However, memory is generally better for more remarkable topics, such as death (Bowling, 2001). One method of checking the accuracy of participants' accounts (respondent validation or member checking) is by returning transcripts to them for feedback. There has been some dispute as to the validity of member checking in qualitative work (Morse, Barrett, Mayan, Olson & Spiers, 2002). *'The problem of member checks is that, with the exception of case study research and some narrative inquiry, study results have been synthesized, decontextualized, and abstracted from (and across) individual participants, so there is no reason for individuals to be able to recognize themselves or their particular experiences.'* (2002:16).

To the researcher, it seemed an important part of the methodology to go back to participants to democratise the process (Carspecken, 1996). To do some member checking, she went into the PICU and interviewed whichever participants were there and available. She performed several of these short interviews to confirm that her findings were in fact the voices of the bed-side nurses and not a display of her own bias or ideals, which do not reflect the participants' lived experiences. Presented by the researcher with broad themes each participant re-interviewed (for member checking) recognised the themes as an overall view of the PICU, but each one asked about their particular focus. The researcher found that she had encompassed all of these foci in the analysis, and could explain to the participants under which heading their individual foci would be discussed.

Coding: Another potential limitation of the methodology of coding was that the researcher was the only person conducting the coding and theory building process. It can be helpful to have more than one person developing the coding scheme and then comparing and discussing the findings (Patton, 2002). This can provide added insights into the data. However, Morse (2006) argues that trying to achieve agreement between multiple coders inhibits the induction processes as coding is interpretive, focusing on identifying what the data signify and not just identifying the face value of the text. The best method the researcher found was to keep records of the research process and discuss all aspects of the study with her research supervisor throughout the process.

Reflexivity

Reflexivity is one of the most important elements of this critical ethnographic research and many qualitative methodologies. Patton (2002) describes reflexivity in qualitative research as a way of emphasising the importance of self awareness, political/cultural consciousness, and ownership of one's perspective.

By being reflective, the researcher's *insider's* perspective benefits both the interview and the analysis process, as the researcher can draw upon personal experiences and theoretical knowledge to generate insights (Holland, 2007). Epistemological reflexivity asks the questions; from where was this study derived, how was the research question defined, could it have been undertaken differently? It also encourages one to reflect upon the assumptions made in the course of the research and to think about the implications of these assumptions for the research findings and conclusions (Holland, 2007).

Willig (2001) notes that there are two types of reflexivity: personal and epistemological. Personal reflexivity involves reflecting upon ways in which one's own values, experiences, beliefs, and political and social identities shape the research. The researcher found it difficult to separate these two components. She did not come to this research without her own defined values, and her perception was part of the context for the findings (Patton, 2002). How else can this type of research be conducted? The researcher concludes it cannot be conducted any other way. The

natural understanding she possesses of the 'ins and outs' of an environment, as seen by the nurse, has to enhance the data positively. She believes it facilitated her ability not to over-analyse the data, and to accept findings she had not expected. In conducting this research the idea of reflexivity became a profoundly personal experience. It requires absolute self-honesty and ongoing questioning of one's motives and ideas. The researcher had not expected this. One is encouraged to remain somewhat remote and non judgemental. However, as an *insider* this becomes impossible. *Insiders* cannot be unmoved or unaffected by the stories they hear. In fact, it may be the great advantage of being the *insider* and this methodology. As suggested earlier, being an *insider* is the only way to conduct CE. *'Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research.'* Nightingale & Cromby, (1999: 228).

A qualitative, critical ethnographic methodology was chosen because the author felt it would reveal in-depth understanding of the PICU nurses' work environment and how this environment might sway their decisions about themselves and their professional position in PICU. The author's cultural, professional, personal and political attributes shaped these primary decisions (Holland, 2007). However, reflecting on her early thoughts and assumptions, she has realised that it was patronising to assume that she understood how staff felt about their work and work environment. Reflexivity allowed her the opportunity to unpack her assumptions and expectations (Woodthorpe, 2009). Only the participant nurses can really reveal the truth about their environment and about how it may or may not affect them. The author's experience with these PICU nurses and their ability to be insightful and honest she describes as 'truly humbling'. She felt proud to be associated with these professionals. This may have had the most impact on the researcher. As a novice researcher she was overly conscious of doing everything 'the right way'. Watching and listening to the participant nurses allowed her to gain confidence as a researcher. She received positive feedback after the interviews. The number of participants who

volunteered and continued to volunteer even after she had closed the interview recruitment was significant. Reflexivity involved ongoing examination of the researchers' influence upon the methodology, data collection, interpretation and analysis and the way in which she wrote about them, as well as the effect that these processes had upon her. She has chosen to research PICU nurses because of her concerns for their lack of job satisfaction and her admiration for their level of expertise and conscientiousness. Inevitably their lack of job satisfaction leads to attrition from the PICU.

Romanoff (2001) noted that the explicit purposes of interviews differ, and that the purpose should be clearly stated. The researcher ensured participants were aware of the purpose of the interview. In practice, investigative research and interview research is often therapeutic for the participants. After every interview, when the audio recorder was switched off, the participant and the researcher discussed the interview and how he or she felt. If an Issue was raised in the interview it was discussed at this time, and on only one occasion was an issue raised. This issue, relating to a potential abuse of power, was discussed; and the author advised the participant to bring this to the attention of the unit manager, offering to accompany the participant, but she felt she was fine to go alone and thanked the author for her advice. The participants clearly stated how therapeutic they found the interviews, almost cathartic, and this researcher must admit that she too found them uplifting and rewarding. Ongoing reflexivity upon her own performance and the emotional impact of doing the research, and the implications of the setting of the research, allowed the author to experience such feelings and to be aware of the influence they could have on her interpretation of the data. She was very conscious of being overly empathetic. This consciousness ensured she did not infuse the findings with her own opinions of PICU nurses. Holland (2007) argues that understanding emotions is essential to the pursuit of knowledge, and that the emotions experienced in the field can bring value to the understanding, analysis and interpretation of the research.

Woodthorpe (2009) notes that intuition and instinct were just part of the complexity and multiplicity of the qualitative research process; and she had to rely on these instincts, occasionally knowing when to give undivided attention and ask questions

and when to just listen and make a quick note about a question and return to it at a later point. She felt it was important to have a relaxed persona and not an overly professional demeanour in order to separate herself from her previous role as leader in the unit. The literature suggests that the interviewer should remain neutral (Bowling, 2001; Patton, 2002), but this researcher found it impossible not to become engaged in the conversation and exhibit empathy and understanding when participants discussed difficult moments. The researcher found her role conflict between neutral research interviewer and empathetic PICU nurse mirrored what other researchers in the caring professions had reported (Carolan, 2003; Valentine, 2007). The researcher was aware of the ongoing need for concern regarding validity and authenticity of the data analysis while having:- *'the sure and certain knowledge that all texts are socially, historically, politically and culturally located'* Lincoln and Denzin, (1994:582). Patton (2002) states that *'reflexivity reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's perspective and voice as well as the perspective and voices of those one interviews and those to whom one reports'* (2002:65).

Kinsella and Whiteford (2009) suggest reflexivity surpasses reflection by introducing a critical dimension to question the conditions under which knowledge claims are accepted and constructed. Holland (2007), notes that there is a cost if this interplay is not recognised and addressed. As a critical ethnographic researcher, the author reflexivity reflects a critical concept. Simon (1992) explains that critical perspectives can open new possibilities and new ways of seeing. This aspect became a profound experience for the researcher as, during her data analysis, she spent many hours listening to the recording of the participant interviews and realised how deconstruction of data (as suggested by Carspecken, 1996) is a tool which facilitates critical reflexivity. Critical reflexivity not only asks one to question current ideology, it also encourages the enactment of change (Freire, 2007). Epistemological reflexivity moves beyond the individual toward the social, and begins to turn one's reflexive gaze on the social conditions under which knowledge is produced within the discipline (Bourdieu & Wacquant, 1992).

Ethical Principles and Issues

The research protocol was approved by the hospital Research Ethics Committee, the affiliate University and by the School for Health Research Ethics Approval Panel at the University of Bath.

Consent: Ensuring that the nurses participated in this project voluntarily and without coercion was an essential ethical consideration in the planning and conduct of this study. Many efforts were made to ensure that the participating nurses understood the nature and purpose of the study and that they comprehended that their participation in the study must be fully voluntary. On a more formal level written consent to participate in the study was directly obtained from participating nurses (*See Appendix D*). The participants' right to withdraw from the project at anytime was explained. Also participants were informed that if at any time during the interview process, they may ask questions of the researcher, they may refuse to answer any question, and they may request that recorded data be erased.

Confidentiality: As it is in our qualitative research projects confidentiality is important ethical consideration during this project. It is acknowledged that ensuring anonymity in qualitative studies is inherently difficult because of small sample sizes and the detailed and personal information given in natural language and the frequent use of direct quotes (Dean and McClement, 2002; Seymour and Ingleton, 2005). Researcher-participant anonymity was impossible in this study, but every effort was made to protect participants' anonymity in reporting it. Participants were assigned a code number, and identifying information was erased. These numbers were assigned at the time the nurse volunteered, not in the order in which they were interviewed, thus further protecting their identity. Only the research team had access to the electronic data and the hard copy data. The digital audio files and transcripts were stored on a secure server, accessible only to the research team. In addition, the participants were assured that any persons they mentioned on the tapes will not have their identity revealed at any time. Again, the participants were reminded that they could end their involvement in the research project at any time (*see Appendix D*).

Being an *insider* creates unique challenges related to coercion and confidentiality. To reduce the power differential effects, the author took a sabbatical from her clinical management position for the project's duration. She handed over all duties to a replacement; most significant duties handed over were nursing performance appraisals. As noted in the previous section, the effects of *insider* status were a topic of ongoing reflection.

The risks and benefits of participating in qualitative research are not always apparent. Interviews may lead to fresh ideas that may cause unanticipated reactions (Kellehear, 1998). There is a possibility that the participants may find the content emotionally upsetting as they recall their experiences in caring for children and their families. If participants required support, they were guided in how to seek assistance. There are limits to how adequately one can inform all interviewees about all aspects of participation (Mason, 1996). However, there were no significant issues identified by the participants following their interviews.

As a nurse researcher the author is governed by the Canadian Nurses Association code of ethics. The link is provided on the consent forms (*See Appendix D*). This code of ethics provides guidance on the nurse's responsibility if bad practices are uncovered. Every effort was made to maintain research-site and participant confidentiality, according to established standards of the Canadian Tri-Council Policy Statement (http://www.nserc-crsng.gc.ca/NSERC-CRSNG/policies-politiques/tpsintegrity-picintegritie_eng.asp).

The author was also very aware of the impact of the research process and data collection on herself. She found the reflective approach very helpful and sought support as necessary through clinical supervision at her workplace and through research supervision at the university.

Rigour in critical ethnography: The researcher's goal in this project was to represent the voices of PICU nurses honestly openly and respectfully. The researcher's aim was to interpret what she heard and learned in order to render the nurses experience in PICU more visible and to locate those experiences in the broader field of

healthcare practice and policy. The researcher recognise the privileged position she held with these nurses, the fact that they trusted her and were willing to share their experiences with her and allow her access to this portion of their work lives. The researcher was determined that this research would represent the features of PICU as experienced by the participating nurses and in a manner that would be informative to those that work with them. For these interpretations to be believable and justifiable the researcher needed to articulate an approach to scientific rigour that will guide the study.

In 1985, Lincoln and Guba set out criteria that they believed to be measures of trustworthiness in qualitative enquiry: credibility, transferability, dependability and confirmability. Since then, the criteria by which qualitative research ought to be judged have been the subject of extensive debate (e.g., Hall & Stevens, 1991; Lincoln & Guba, 1985; Thorne, 2002). These debates have variously grappled with topics such as differences between quantitative and qualitative enquiry and the consequent translation into measures of quality, and whether strict adherence to specific research traditions (and the adoption of the corresponding epistemological and ontological commitments) is essential to the development of credibility and trustworthy knowledge.

It was within this array of perspectives on quality in qualitative research that the researcher needed to critically consider the integrity of this project. Specifically, the researcher needed to understand what theoretical and practical problems might threaten the validity of the project, and what techniques might emphasises credibility and relevance. The researcher came to understand rigour as the process through which the scientific process is shown to be consistent with the researcher's claims about knowledge and knowledge development (*as described in Chapter 2*). The researcher ensured that every effort was made to ensure scientific integrity in this project by endeavouring to make the analytic processes explicit.

Credibility: In the project credibility demanded awareness of and attention to the efforts of the researcher herself in her power and her vulnerabilities across all aspects of the research project. Her perspectives on this work are grounded in her experience

as a PICU nurse. Reflection on these beliefs was paramount in the early stages of this project particularly as the researcher worked to establish the research question and as she decided what theoretical approach held relevance in this enquiry (*See reflexivity page 50*). The researcher came to this project with certain beliefs and assumptions that shape the project that influence what she was looking for, what she could see, and where she looked as endeavouring to learn about PICU nurses experience and the effect of environmental influences. For example, she believed that senior nurses and junior nurses were engaged in an ongoing power struggle (*See Appendix A*).

The credibility of the findings must also be judged by the quality of the data the researcher was able to gather. The researcher thinks that the quality of the data in this project was intricately related to the relationships that developed between the researcher and the participants. There is no doubt that the quality of those relationships varied widely. There were times in this study where the researcher questioned overall quality of the data. However once the interviews began, the more apparent it became that the data being collected was rich and descriptive. As will become evident in the interpretation presented in chapters 4 and 5 the researcher could see the data shifted and came to understand the kinds of stories or fragments of stories the participants told in different ways. So the quality of the data was influenced not only by the nature of the researcher's relationship to the participants but was also related to what was recorded, what was interesting to the researcher and on what the researcher could see.

For the study to be credible the interpretations must be justifiable as the researcher depicted the interpretations she proposed as the findings of the study in chapters 4 and five. The credibility of this study's findings rest on the extent to which the interpretations presented by the researcher are convincing, defensible in the data and ring true for those who hear it. The researcher endeavoured to depict the logical trails that lead her to these interpretations. In many instances, the interpretations are clearly linked to the analytical framework she presented in chapter 2 and 3.

Relevance: In addition to establishing credibility, rigour in critical ethnography demands attention to the relevance of the project and the findings to those whose

lives are affected by the phenomenal under investigation. In particular, in this project the researcher must scrutinise the interpretations to ensure they express meaning for nurses as they work in PICU and for policymakers as they grapple decisions that affects nurses' work environment. In one effort to address this aspect of ensuring integrity, the researcher sought feedback in various places from expert nurses in the field, and through two presentations at academic conferences. Nurses in clinical practice confirm that the emerging interpretations provided a useful mental heuristic for understanding the environmental influences on PICU nurses. In every instance, the nurses raised new examples that challenged or confirmed the researcher's interpretations or asked questions that assisted the researcher in clarifying her own concepts. Feedback from peers at conferences prompted further reflection on assumptions that underpin concept of participation and cause a research to reflect on and grapple further with the intricacies of persistent agent structured issues.

As the researcher listened to the participant PICU nurses and others spoke with other healthcare professionals, and as the researcher engaged in critical questioning of the assumptions that underpin the study the researchers understanding of what it might influence PICU nurses and what is important about those influences began to shift. The data set generated in the study created challenges that caused the researcher to rethink concepts of participant and environmental influences. She began to understand what PICU nurses were saying was important to them in new ways, and begin to comprehend what might encourage PICU nurses to stay in the PICU environment. In chapters 4 and 5, the researcher describes what she has come to understand as what constituent the nurses' voices in PICU. The researcher endeavoured to link the notion of environmental and cultural influences on nurses within PICU and the hospital.

How Data are Stored: It is imperative to safeguard participants' privacy. This means ensuring that personal information documented as part of the study is kept confidential (Johnson, Buchanan, Long, Peacock and Williamson, 2004).

Electronic files are stored on a secured dedicated computer, to which only the researcher and the researcher's practice supervisor will have access. Hard copies of

consent forms and data were stored in a locked cabinet at the research site for the duration of the study, after which the data was transferred for storage at the University's School of Nursing.

Information about Data Protection Arrangements: Electronic data are stored on a secure network drive in the School of Nursing at the University for a period of five years following study completion. Hard copy forms and data are stored in a locked cabinet in the same location. At the end of five years, hard copies will be shredded and electronic files will be erased.

Summary

This chapter described the methods used for this study of the environmental influences on PICU nurses' decisions to stay in or leave bed-side nursing in the PICU. The study was based within an epistemology of health services research and underpinned by a philosophy of realist/interpretivism. The research aim was outlined, which was to examine key features of the cultural context of the PICU environment as experienced by nurses, and to identify what these influences are, and how they shape nurses' intentions to continue in this environment or to leave nursing. To meet the aim, a qualitative design was adopted following a CE approach. The methods used were in-depth, semi-structured interviews and unobtrusive observation. The process of sampling from a population of PICU nurses and the characteristics of the sample are described and illustrated. The author described why she followed a critical ethnographic theory approach with the processes of constant comparative analysis.

The limitations of the methodology, the importance of reflexivity and the ethical background to the study have also been discussed. The research findings are described and discussed in the following chapters.

CHAPTER 4: FINDINGS

Introduction

The previous two chapters discussed the issues involved in staff retention in PICU and established why Critical Ethnography (CE) is an appropriate methodology for this research. This chapter commences with a review of the aim of this study and an overview of the findings. The findings and a final analysis of this study are presented, using a critical ethnographic approach as outlined by Carspecken (1996). Here the environmental influences on the nurse from a CE perspective are considered, as well as how these factors might influence PICU nurses to leave or stay at the bed-side in PICU.

The overarching theme of caring will be discussed. Caring is an integral part of nursing and has a significant influence on PICU nurses work. Some unique findings that are specific to PICU are presented. The most influential component of PICU nurses' experience and what keeps them in PICU is becoming an expert and the status acquired by being an expert. From the research it became apparent that becoming a PICU nurse expert is a process. This process will be explored in this chapter, where the components involved in becoming an expert PICU nurse are shown under the following headings: Becoming an Expert, Undergoing Peer Review and Entering the Inner Sanctum. Also discussed are the Conflicts and Contradictions found in the PICU environment from the nurses' perspective. This is discussed under the following headings: Lack of Control, Growing Old, Isolation and Being Held Hostage.

Aim

The aim of this study is to examine key features within the cultural context in a Canadian Paediatric Intensive Care Unit (PICU) environment as experienced by nurses, and to identify what these influences are and how they shape nurses' intentions to remain at critically ill children's bed-sides for the duration of their careers.

As described in Chapter 2, PICU is a unique environment, requiring significant training and experience of its workers. In order to understand the PICU one must

understand its position in this children's hospital. ICU is considered the centre upon which all other aspects of care in the hospital rely for immediate medical response in an emergency. It is the source of extreme treatments and advanced technology. PICU is the site of care for the sickest children in the hospital. Paediatrics, working with children, whom we consider to be innocent and completely undeserving of any suffering, adds an extra emotional component to nursing. This is apparent from the data. In order to understand the key features of the PICU environment we must view them from the PICU nurses' perspective. In this research the participant nurses were asked to describe their work and their work environment. In doing this each participant nurse described his or her own experience. The analysis is guided by Carspecken's five stage model. These stages were discussed in depth in Chapter 3 (and see *Figure 3*).

The Complexities of Caring

Caring has been defined as '*the mental, emotional, and physical effort involved in looking after, responding to, and supporting others*' Baines et al., (1991:11). Many nurse theorists have described caring as central to nursing's role and as being the defining characteristic of nursing (Benner & Wrubel, 1989; Watson, 1990; Swanson, 1993). Caring can have profound implications for performers of caring roles, as it involves 'emotional labour' (EL). The theoretical concepts of caring are discussed further in Chapter Five. In this chapter, the practical aspects of caring are demonstrated using examples from participants' comments at interview sessions. The participants portrayed many features of this emotional work that had implications for their job satisfaction and that may influence their willingness to continue in a bed-nursing role. These features include their opportunities to care for family members as well as the child alone; the crucial issue of time and the effects of lack of time on their abilities to do the job well; and, in relation to death, the opportunity to create the conditions where a 'good death' can unfold.

Family Centred Care (FCC): It is known that ICU areas are vulnerable to staff turnover and shortages because of stress or burnout (Cartledge, 2001; Daines, 2000). However, the PICU nurse has another component that influences job satisfaction: the integration of families into the child's care (Bratt et al., 2000). The relationships

developed with families in this intense and often tragic period of a child's life are fundamental to the nurse's concept of being satisfied with his/her work. The nurse does not care for the child in isolation; rather, he/she cares for the family as a unit with the child at the centre. Throughout most of the interviews, nurses described a true compassion or a bond that develops with the parent or the primary caregiver for the patient. Interestingly, these bonds usually develop in the most stressful of times for the family. **Participant 29** states this clearly, *'I guess partly I mean that is one of the things I like about ICU is you are involved usually with one patient and you really do get to be involved with the family and really do get to help and support the whole family through this terrible time not just the child in the bed.'* Most participants describe a maternal/paternal-like response to the child. This culminates in the use of ownership descriptors such as 'my kid today is the cardiac kid'. This again evokes the theme of power or power imbalances between the parents and the bed-side nurses. The nurses describe what can be considered a sense of surrogacy toward their patients. This becomes manifested in their sense of responsibility and protectiveness towards the patient, as when they may believe they have to protect the patient from the parent. This is not from physical harm but more in the sense of protecting the child from the parent's natural desire to be involved, touch and hold the child, for example. Most participants believed they have a 'cellular' (intimate) connection with the patient.

Participant 11 describes how a certain nurturing behaviour exhibited by nurses may possibly be due to gender difference, the majority of PICU nurses being female. However, some male nurses also exhibit similar traits. This may simply be due to paternal feelings rather than gender, or it may be a professional trait. *'....we're in this profession not for the glamour but for the fact that we actually care about the work that we do and care about the patients and particularly care about the kids, so I think that a personality trait of a nurse is to be very protective and it's kind of like this mother caring for her cubs kind of scenario that you want to make sure that that outsider (the parent) is okay before they come in and take over your space and a territorial thing maybe.'*

This brings one to consider why certain people go into certain professions; invoking the theory of vocation. Although vocation is not unique to women, the male dominated priesthood is considered. However, medicine is also considered a vocation. The vocation being described here is not a religious 'calling' it is more an understanding that this is where one should be and this is what one should be doing. Nurturing and possession of the patient seems to be a key component and an expectation of the PICU nurse. This sense of responsibility and bonding with the patient may not be unique to paediatric nursing. It may exist in early childhood educators and similar professions, also predominantly female-dominated professions. *'The teacher-child relationship is an extension of the primary parent-child relationship, and teachers invest in building supportive relationships with families around their common interest, the child'* Edwards & Raikes, (2002: 12). Although all of the participants describe this connection to the child, very few of them actually approve of the idea of being too involved with patients and or families outside the hospital setting. They believe they should have some distance. Indeed, they expect their colleagues to be able to keep a degree of distance between themselves and the patient.

During stressful times families can react aggressively (usually verbally) and almost all staff excuse these aggressive attacks as a stress response. They describe these outbursts as understandable and say that they themselves might respond the same way, and they all described a similar method of talking the family member down or out of this level of agitated distress. Participants' qualified the parents' right to be angry or upset. They asked what it was the parents needed or wanted in order to address the issues that were upsetting them; and they all took the time to listen and act, or facilitate some kind of action, in order to help or appease the parent. The majority of parents offered apologies and were very grateful after these interventions. **Participant 29** describes how nurses give permission to the family to express their anger. *'I gave them that permission to ... vent and tell me what they're thinking, I gave them permission to feel the way they were feeling and whether they were right or wrong didn't matter, that whatever they're feeling was what they were feeling and that was OK.'* Although a large amount of time is required for this kind of family-centred care, nurses are proud of their ability to intervene on behalf of parents to

improve the overall situation. Nurses display a communication style in which they are not necessarily educated. There is some education around dealing with the aggressive person but it is minimal. This displays the nurses' natural sympathy for or empathy with the parent/caregiver and their desire to help them through this most difficult of times, to 'do good' by them. Here we can see how the nurse is the advocate for the patient *and* for the parent/caregiver.

Some of these questions are answered here by **Participant 13**. *'And in your other interactions with medicine, it's very person-dependent. Some people are more, introduce themselves, and consider you as part of their team. I find the majority don't, they just walk up, and they just basically do their job.'* **Researcher:** *'How does that make you feel?'* **Participant 13** *'It makes you feel like you don't matter. It's like the same thing as people talking to the housekeepers and just directing them and don't talk to them, just direct. And I just find it's, it doesn't help anybody feel like they're sort of a part of this team.'*

Participant 24 describes how she believes the predominantly female management group makes a decision surrounding a staff member and her nursing abilities. *'I think it's typical nursing. I think it's typical women. You get it in your head, it's a personal opinion ... sometimes I think it's meant to be vicious just because that's the nature of a female-dominated profession and sometimes it's just sort of a passive thing that just sort of happens..... The more I think if you go to your Clinical Nurse Coordinator and try to work that out and nothing ever happens, I think that's even more deflating.'* **Participant 19** described in detail how she believes nurses are taught to communicate, and then have to change how they communicate to physicians in order to be understood; they believe they learn how to communicate in PICU. She also explored how men and women communicate differently. *'.... So that's one of the things I think we learn as ICU nurses, to be more objective, but I think we could still be better at it. I think that we're more subjective. We speak more subjectively because we're women. Probably because we're nurses as well, with the way that we were taught. I don't know that I necessarily agree with the way that we're taught in nursing school. I think that we should be following more of the medical... I think it's the way that we're taught and also the fact that we're women and we probably do tend to speak more with feelings.'* **Participant 4A** believes that society imposes a

power imbalance on nursing, or a judgment on nursing as less informed, less schooled, and the handmaiden of medicine. *'Society views doctors differently. Doctors are more influential for a lot of people ... a lot of people would assume that physicians have more training and are more influential ... I think a lot of people think my job is as a doctor's assistant, that's the view point that's out there; Maybe that is our downfall, that we do not present ourselves properly, we do not present ourselves as a member of the team just like the physician'*

Participant 24 described a more evolved form of communication. She described certain life skills that people develop with maturity. This participant considered the difference between her ability to communicate and how that relates to self-confidence, and how self-confidence grows as a person's knowledge and skills improve. *'I think to a certain extent I had life skills to know priorities vs. whatever, but obviously you learn a whole new skill set when you come into ICU.... You know both are important but prioritising and sorting it out, it's definitely something you learn as you go.'* One participant explained how she mentored a junior nurse in communications on rounds. **Participant 19:** *'We learn to be more objective.... I try to encourage some of the younger staff; I try to show them that if you say things objectively, you'll often get a response...'* **Participant 25** (a male nurse) described the female-dominated environment of nursing, and the very specific types of communication that he described as emotionally driven. *'I find that there's a lot of,.. it's sometimes a breath of fresh air to have a male nurse because we're much more, I don't know a good way of putting this, but we're more cut and dried, ...we're much more objective, I don't feel that I let emotions play a role in what we do as much as some of my female co-workers. I find that you stand out and you can stand out for the good or you can stand out for the bad, whichever way you portray yourself.'*

The following participant described nurse-to-nurse communication. **Researcher:** *'You mentioned that you ended up doing a fair amount of teaching to the more junior staff. Do you see that as part of your role?'* **Participant 24:** *'Absolutely. That's what we're here for. If we can't pass on our knowledge what are we doing here? And doing it effectively I think is the key. Because some people have a lot of knowledge*

but if you can't pass it on without some sort of semblance of clarity ... you have to be able to do that.'

While the opinions of the Management group (Clinical Leaders, Managers, Educators and the like) were seen to be negative and to a degree an abuse of power, they were also often seen as favouritism or at least subjective judgments (Henderson, 2001). Bourdieu goes further to discuss the power involved in these processes. For Bourdieu, '*social capital is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.*' Bourdieu & Wacquant, (1992: 119). Bourdieu sees symbolic capital (e.g. prestige) as a crucial source of power. When a holder of symbolic capital uses the power this confers on him/her and seeks to alter another's actions, the holder exercises 'symbolic violence'.

Participant 24 describes this by describing a nurse she watched become disillusioned with the PICU. '*Well there is one particular nurse on today and for whatever reason some of the management team have just decided that she's not ICU material but she is great. Put her with this patient or put her next to this nurse dealing with the more critical so that she can do the breaks. It's always, 'No, I don't think she handle it', or if I'm in charge, I'll put her there and then I come back for the next shift and she's been moved. And she's a smart person, but you see it every time she comes in, the face is like done ... Her ambition when she first came here, so ready to do it, so excited, so ambitious, everything, wanted to learn, totally involved, and then you can only be kicked so many times before you just back off.*'

Another interesting angle on advocacy and nursing is that the nurse often finds herself an advocate for medicine. Nurses have described how parents may misinterpret, mis-hear or misunderstand what the physician has told them with regards to their child. The nurse is usually happy to clarify with the physician exactly what was said so he/she can explain it to parents. This goes beyond nursing advocacy, it also displays a team approach to care; although subtle it is very important for interdisciplinary relationships. This type of intervention develops trust between the disciplines and improves communication and, inevitably, patient care.

Participant 13 describes this as being an interpreter: *'you just have to sort of juggle two camps and you're the one that's always present so you're the one that's there and you're the one that's there for medicine and there for the parents. After the doctor has been in you then say to parents "okay this is what he means by this, and he didn't mean to say this but he meant it in this way, that this is what we're gonna do". So I think... you're sort of an interpreter and a liaison I guess as well.'*

When FCC is discussed with nurses they often express misgivings regarding the concept of FCC. For example, **Participant 5A** was discussing FCC and caring for her patient and said she resented being 'pushed' by the Clinical Nursing Specialist (CNS) to take care of a particular patient's family. The CNS was focusing on consistency for the family. The nurse described a situation where she believed she was being directed to care for the family to the detriment of her patient, causing an internal conflict. She described how she can prioritise and encompass care of the family as a whole. *'It's tiresome sometimes to always have to deal with families when you have a busy child. I want to focus on the child, but you're really pushed by the CNS to look after the whole picture when really at that time, you look after the whole picture when you have the time and when it's appropriate. But when a child is sick and needs your care, you have to focus on the child. I like to put the child at the centre, make them the most important.'* **Participant 24** describes how her skills of prioritising may conflict with the concept of FCC: *'... maybe talking to mom isn't the first priority when the patient's blood pressure is in his boots. So those are things that you learn.'*

The very nature of FCC as described above intensifies EL in the PICU. **Participant 16** describes this 'genuine authenticity' and true indulgence of the 'self' in his/her work or EL. Here the participant takes the parent's perspective, humanising this experience, and admires the great capacity of the human spirit. *'You know, after 36 years of ICU, for me to walk into a room where a kid is canulated through his heart and his chest is open and it really sets me back. I have to take a deep breath, sort myself out before I walk in there. How can parents cope with that? How? I have no idea how they do it and in most cases we don't have the outcomes we're looking for ... and I have so much respect for these parents who can sit at that bed-side and*

overlook all that and touch their child and talk to their child and not see all of that graphic technology that is just as far as we can go ... they talk to those babies and they hold their hands and they touch, sing to them. Those parents are amazing. I don't know if I could do that even having done what I've done for all these years. They really impress me.'

It is clear that these participant nurses experience strong emotions in the context of their work but also use those emotions to improve their practice. This was very apparent in the emotions displayed by nurses when relating these stories to the researcher. The author noted how many nurses were close to tears when relating their stories. Smith (1992) observed that nurses recognised that there is an expectation that he/she appears happy. There is also an expectation that they appear to manage and cope with extremes of feelings. The nurse learns to turn on and off her work persona; this finding was confirmed by the author's observations of nurses in the PICU, when they became close to tears they would laugh or make an excuse for their emotional state.

Millward (1995) identified that nurses feel that care is an essential component of cure. Millward goes further to conclude that for nurses '*the patient-centred interpersonal orientation ... is central to the claim for professional distinctiveness*' (1995:319).

Participant 16 describes the support of family centred care and the time one is encouraged to take with families as one of the most important aspects of her work. Having this time improves the participants' concept of job satisfaction. '*I think in Children's Hospital, that one of the biggest changes over my years is family-centered care. Because we do family-centered care now, we know the families better, we respect the families more, and so we can see their point of view, we can talk to them more easily about what they need and how we can help them. It used to be, when I started, you could come and see your kid from 2-4 and from 7- 8. That was it. And then you were gone. We hardly knew the moms. We didn't know if there were siblings. We didn't know if there were dads. We didn't know where you came from. We just knew we were going to fix the kid and you take him home and thank you very*

much. Unbelievable. I truly think that's the biggest, the best change in paediatric nursing. Way past all the technology is the fact that we look after families now and not just kids. I think that one of the reasons why we're so much better at helping these people with their deaths is because we know them.' **Researcher:** *Do you consider that to be a significant part of your job?* **Participant 16:** *'Yeah. The most important part of my job, and that's one of the best parts of my job.'*

Care of the family as a whole became a central theme in this research. Caring for the family implies that the nurse or the healthcare worker does not care for a child in isolation but recognises the needs of the family as a whole, regardless of how that family is configured. Generally by consensus the participants agreed that care of the family takes significantly more time to accomplish than the isolated care of the child/patient. It also gives the participants the ability to display their expertise to families and colleagues by using their skills to improve the health, both physical and psychological, of the child and the family, and 'to do good'. Not having this time to spend with families appears to cause great frustration and job dissatisfaction in participants. This is mainly due to the feeling of being taken for granted or not appreciated, again leading to frustration and anger. Participants described this type of frustration in their day-to-day work when they have two patients, or if they are floated to another unit. **Participant 31** described a situation where she was doubled and felt she could not do her job due to this lack of time. *'I came on and I was doubled, with a post-renal transplant and a kid on high flow oxygen. So it was a really heavy double. It should have been a great learning experience for my student but unfortunately it was not a great learning experience because I wasn't able to do any teaching. She was left primarily on her own to care for one of the patients and I kinda cared for the other one and helped her out as much as I could ... It was quite chaotic and overwhelming for me. I felt very guilty not being able to provide any support for this poor student. I felt guilty about not being able to care for my patients like I would like to.'*

The value placed on the time dedicated to family-centred care is held in very high regard by the participants. The participants described a 'job well done' when they knew they had the time, expertise and ability to fully care for the family as a unit.

Participant 12: *‘That experience made me feel really good that I had actually listened to the family and advocated for them; sometimes we listen but we don’t really listen or we impose what we think on them and it just made me feel really good that the outcome was what the family really wanted. There have been lots of good things about working here. I like my job here.’*

Not having enough time caused feelings of guilt and regret, often leading to agitation and anger – this anger was usually directed towards a system that does not account for the importance of a nurse’s time with a family and the patient. This would be considered a negative effect of EL, which should have been mitigated by the presence of FCC.

A Good Death: One of the contradictory notions to this maternal/paternal possessive component of PICU nurses is their response during or at the time of death of a patient. These same nurses, who have described these very real feelings of maternalism, can remove themselves from the equation and go out of their way to facilitate as tolerable a death for the child and for the family or primary caregiver of the child. In general, staff did not describe death as a traumatic event for them although they recognise it as traumatic for the family. Once appropriate time is allowed they find that it is a very ‘satisfying’ process. They believe they have made one of the most difficult times a little easier by their presence and their interactions with the child and family. Again, the author considers that this aspect of caring invokes the concept of vocation and ‘doing-good’. It is described by several nurses as one of the most satisfying aspects of their job. Participants’ desire is to make the worst time in the lives of these children and their families a little more tolerable or less traumatic, by responding effectively to their requests at this tragic time. Participants describe these experiences with a degree of satisfaction. Several of them became tearful when remembering these deaths but their upset was not lasting or subjective; rather the interviewer saw it as the sadness of an occasion. The participants believe they made a bad situation better. The following are some very poignant examples from several participants. The majority of participants discussed death in this positive perspective.

Describing her work in caring for two dying children who were being kept alive in order to harvest their organs, **Participant 26** said: *'I had both of them and I wanted to have both of them because I was gonna wrap both of them... It was very good ... I developed a really strong bond with the family and I felt like I did a really, really good job ... I think there is something very unique about this job ... you see people at their worst times and it's really hard on you, it's very emotionally draining, you feel like you're just becoming part of that family. But it is also very special.'* **Participant 18** articulated her passion for families and the great satisfaction that comes from caring for a family at the time of child death. *'...what I love about it is working with families who are in the process of losing a child and walking with them through that experience; it's a real privilege to be a part of that. And if there's anything that I can do to make that experience a bit more gentle for them, then I've done a good job. ... my job I really see as helping the family,making it more gentle for the patient ... as we can for the families to really have those memories of a goodbye.'*

Participant 5A expressed the concept of caring beautifully. **Researcher:** *'When children are dying and you have the time to be with parents, what do you do, as their nurse in PICU?'* *'I think when it comes to death and dying that the parents need the strength of someone; they need someone to take control. I think one of the things that I've learned at the beginning of my career was to be very careful what you say. Hardly say anything but just be there, be pleasant, and it doesn't take much, a glass of water, a smile, a warm blanket, a little hug, but don't go too far, just be very cautious what you say and how you say it . They just want, it's their time, it's their child, we should be in the background where they'll say it was a kind nurse but I don't really know who she was.....because I think death is a beautiful experience even if it's tragic, it can be just as beautiful as being born.'*

This is not to imply that the more dramatic unanticipated death in PICU does not affect the nurse. The unplanned more dramatic death can be very challenging for the nurse in PICU. However, it is the time to support the family that appears to bring the most comfort and satisfaction to the PICU nurse. **Participant 3** describes a very traumatic event – however, she manages to express her ability to remove herself

from the equation, realising the real tragedy was that the family has to have this memory of their precious child. *'I was the nurse at the bed-side ... a 3-4 kg baby that's bleeding profusely ... the bed was just getting saturated (with blood)... and I found myself... mopping up around the baby to try and make it not look like a blood bath because that's what it kind of felt like. And mom walked in oh my goodness, ... she took one look and turned around and walked back out, asked to speak with Dr X, She basically said that enough is enough ... I don't wanna continue as it's not worthwhile. ... the baby died, mom had stepped out and we basically clamped everything off and wrapped him up and mom came back to have her cuddle and dad was there as well but mom was the one that was gonna be ... putting the baby in her arms and she started crying saying that this wasn't supposed to be this way and this wasn't supposed to happen like this ... I was just feeling overwhelmed, that was one of my first deaths that I had had here.'*

PICU deaths are relatively infrequent (>2% of all admissions) and thus would appear to have less impact on burnout for the PICU participant nurse than for ICU nurses in the adult world (Bratz et al., 1989; Duquette et al., 1994). The researcher concluded that death did not necessarily induce moral distress in the majority of PICU nurses interviewed. Moral distress is a state in which a person feels they cannot do what they feel is right (Corley, 2002). **Participant 16** describes the feelings she experiences related to her powerlessness surrounding some of the newer surgical techniques.

'Thirty-six years ago it was a mustard⁴ and detouring them and stents and that's what I remind myself of when I see Norwood⁵, cause Norwood still frustrates me and frightened me because I don't know what kind of a life we've given those kids ... You

⁴ The Mustard procedure was developed in 1963 by Dr. William Mustard at the Hospital for Sick Children in Toronto, Canada. It was the first surgical procedure to show that congenital heart defects could be repaired.

⁵ The Norwood Procedure is a surgery performed on the heart, the first successful use of the procedure was reported by Norwood and colleagues in 1981. This procedure is most often performed to treat Hypoplastic Left Heart Syndrome, certain types of mitral atresia, or other conditions that result in single ventricle circulation.

know we didn't do mustards (30 years ago) or any of those other things so they are 6 or 8 months old and their fingers were clubbed and they were emaciated and blue and sweaty and this is within a week. It isn't quite as simple as that but still it is pretty good and I really have to remind myself of that when I get really down about some of the Norwoods'. It's whether or not the method outweighs the madness that I have trouble dealing with sometimes with those kids. Their quality of life is so miserable that should we really be doing this?'

Becoming an Expert PICU Nurse

In analysing the data, the author discovered that in order to understand the PICU environment from a nurse's perspective, first she had to understand the PICU nurse's own ambitions or drive, and what it means to him/her to be a PICU nurse. The data reveals the importance of being accepted into this environment; and this acceptance depends on becoming an expert in one's given professional field. The transition from junior to senior nurse or novice to expert nurse is a major factor in determining how nurses are influenced by the PICU environment, and their levels of job satisfaction.

Part of becoming an expert is both formal and informal peer review; the majority of participants (including nurses who no longer work full time in the PICU) describe their environment in terms of how they are regarded by their peers (discussed more fully in the next section). This is also reflected in the researcher's own observations and field notes. She was informed by Bourdieu's concept of *habitus*. Becoming an expert PICU nurse can easily fit into this theory, where knowledge is the *capital* and the PICU team is the *field* into which the nurse wishes to gain access. The researcher believes that *habitus* was an appropriate epistemological concept to consider.

Habitus can be seen as the schema for how nurses think about the key environmental features of PICU, where this method of thinking about the world becomes taken for granted by the nurse.

To understand the process of becoming an expert in PICU we must first understand what an expert nurse is. Benner (1984) adapted the model originally proposed by Dreyfus and Dreyfus (1980) and described nurses as passing through five levels of development: novice, advanced beginner, competent, proficient, and expert. Each

step builds on the previous one as abstract principles are refined and expanded by experience, and the learner gains clinical expertise. Instead of seeing patient care as pieces of unrelated information and a series of tasks, the expert is able to integrate various aspects of patient care into a meaningful whole. An expert nurse caring for a specific patient would complete the same tasks as a non-expert nurse, but not be caught up in the technical details. The expert integrates both physiological and pathophysiological knowledge to assess patient signs and symptoms and guide patient care; the expert knows what to observe. The expert has gone beyond the initial task performance, to evaluate and respond to the whole picture. This is consistent with the research findings. The researcher's findings develop this concept/theory of 'novice to expert' in the particular context of PICU nursing. The educational, emotional and maturing experiences a PICU nurse undergoes to become an expert in that field is complex. The knowledge gained in a PICU is unique to PIC and is not found in any other area of nursing. In the PICU this is the path to belonging and acceptance. The findings suggest that becoming an expert implies a gain in power and status. This could be seen to extend Benner's work on 'novice to expert'.

It will help the reader to understand why nurses stay in the PICU if they understand how nurses originally came to work in PICU. The idea of becoming a PICU nurse became a significant topic of discussion in the interviews. The reasons given for this choice were vague: the majority of the participants did not choose the PICU; it seemed to be somewhat serendipitous.

Researcher: 'Why did you choose to work in the PICU?' **Participant 11:** 'I think it maybe chose me.' **Participant 16:** 'I think in the beginning ICU chose me.'

Participant 8: 'I did not choose it because it was given to me, I didn't have a choice.'

Almost all of the participants had worked in paediatrics before coming to the ICU; some people referred to working with children as a draw to the PICU, but the majority had made the decision to work with children well before they came to the PICU. On the other hand, there were a significant proportion of participants who chose PICU for the challenge and the advanced technological component. These nurses expected to further their education and to gain unique and complex skills.

Participant 5: ‘...so I thought coming down here would be a good opportunity to gain even more skills.’ **Participant 6:** ‘Because I wanted the complexity. I wanted to increase my skills, increase my knowledge base, and a lot of it was for the complexity of it.’

Some of these findings suggest that nurses often believe they were born to work in PICU. There is an underlying belief that they are somehow fated to this type of work. All the interviews started with the same question ‘*Why did you choose to work in PICU?*’ The answers varied from indicating no particular desire or forethought to a specific and definite decision. However, from the intonation or manner with which the majority of the participants expressed these ideas, it became apparent that there was an underlying belief that they were ‘fated’ to PICU either by choice or by some external force: ‘*I didn’t pick PICU, it picked me*’.

The idea that staff were joined together to ‘save children’s lives’ appeared very important. There seems to be an internalised concept of the greater good. The majority of participants stated that they love their job. Most of the participants realised that this was a vague statement and went on to justify what loving the job meant to them. In general it meant ‘doing good’; they identified their job as a part of who they are – to some degree part of their identity. **Participant 26** describes her job as ‘*at times it was horrible. But it is also really good, there’s something about it. (I’m getting emotional) ...*’

All of these statements were made with a degree of pride in their personal achievements at acquiring expert status in the PICU environment, at maintaining a level of skill, and of knowing that other people knew they had those skills. Throughout all of the interviews this idea seemed recurrent. In trying to understand what this meant both to staff themselves and on a more objective basis why they feel or express it so, the researcher conceived the theme behind this concept as *vocation*.

When participants describe why or how they entered into PICU nursing, they often describe it as a ‘calling’ or sense of vocation. This was not confined to those who chose to come to a PICU, but also included those who just happened to end up in

PICU. The term vocation can be somewhat controversial, as it can invoke a religious connotation. Many of the world's religions encourage benevolence, and it was the Christian value of 'love thy neighbour as thyself' that had a significant impact on the development of Western nursing (Kozier, Erb, Berman & Snyder, 2004). Modern nurses, however, appear to have humanitarian concepts without a religious component.

Participants believe that PICU is 'where they are meant to be'. This is usually because they believe they are good at it and not everyone can do it. This self-realisation appears to develop when the nurse becomes an expert. This is similar to Patricia Benner's theory on novice-to-expert nursing (1984). Benner's research focused on critical care nurses. In her work *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, as discussed earlier, Benner introduced the concept that expert nurses develop skills and understanding of patient care over time through a solid educational base and a multitude of experiences. Benner suggests that one can gain knowledge and skills ('knowing how') without learning the theory ('knowing that'). Her theory is based on the concept that the development of knowledge in applied disciplines is composed of the extension of practical knowledge ('know-how') through research and the understanding of the 'know how' of clinical experience. Experience is a prerequisite of becoming an expert.

The theme of power is embedded in the novice-to-expert model (Benner, 1984). The natural lack of trust and a certain disdain displayed towards the junior nurse or new nurse by the senior nurse are traits of power and an example of a power imbalance. However, this may possibly be necessary in the evolution of the novice to expert nurse as it is part of the peer review process.

Undergoing Peer Review

This was seen as one of the most important aspects of being accepted as an expert in the PICU. It was seen as the final authority when judging skills and expertise in the PICU. This process is both formal and informal. When nurses start their training in PICU they are paired with a senior nurse who gives a formalised report to the coordinator and the educator on each nurse's performance. When participants

describe their journey from junior to senior PICU nurse they discuss peer review. They recognise peer review as one of the most important elements of their progress or maturation. They also note that a successful peer review means becoming part of the PICU team. The ideas of trust and power are paramount to the concept of peer review in these interviews. The new member of staff is 'watched' and, once proven by his/her actions and knowledge to be a safe practitioner, is accepted. Acceptance is the more informal portion of peer review.

The data show that the new nurse in PICU, by the very nature of being new, is not trusted; new nurses have to prove themselves. If they have no prior experience they will have to prove that they know how to ask questions, find information and display a level of observation that will keep their patients safe. If they have PICU experience, they need to do all of the above with a certain amount of speed, and display significant knowledge. **Participant 23**, in describing her preparation for peer review where she watches and evaluates her colleagues' abilities as nurses, and makes judgments on the basis of her vigilant observations: *'... by visually observing or seeing how they work at the bed-side. You can even tell what kind of critical thinking is used in regards to when they communicate to you, relay the information when you go to break ...'*

Having passed the test (reviewed by their peers), nurses find themselves belonging in this PICU. **Participant 3** describes the very personal feeling of belonging in PICU and how it makes her feel when she knows that other health care workers consider her to be an expert. She describes being part of a team and the comfort that belonging brings. *"... people know me by name and it's nurses, dieticians, physios, occupational therapists, I've worked over the years with. Um, it's how we can do really good work, and be very focused on ... what we're doing and at the same time still manage to have some fun and some jovial times when they're appropriate but we keep each other up and we're supportive of each other; and for the most part people are pretty active in wanting to maintain this as a healthy workplace and a good place to work and there's ebbs and flows with that, of course; but realistically I think there has always been a core positive feeling with the desire to make this a great place to be and work.'*

Once they do achieve the expert level, nurses wear their experience and expertise like a trophy. This was especially evident from the researchers' observations.

"Nurse #1 washes her hands and returns to her empty bedside to discuss whether or not to go on her break with nurse #2, who is at the bedside next door. Nurse #2 (junior ICU RN) agrees that nurse #1 should go on break now while the patient is in the operating room. Nurse #1 and nurse #2 would have been designated to relieve each other for breaks by the charge nurse on morning rounds. Nurse #1 goes back to her bedside, quickly checks that everything she needs for her patient is in place and leaves for the evening break. As she leaves she confirms to nurse #2 that she is going off the unit to get some coffee and asks nurse #2 to call if the operating room call the unit to give an expect time of arrival for her patient returns.

(Observer Comment – Nurses are cordial and cooperative)

Possible subject of claims

Foregrounded, immediate - "We are very organised"

Less foregrounded, less immediate - "We are good at our jobs"

Possible objective claims

Quite foregrounded, quite immediate - "The unit is quiet and organised"

Highly backgrounded, remote, taken for granted- "Our patients are safe"

Possible normative-evaluative claims

Quite foregrounded, quite immediate - "It is good to be on top of things"

Less foregrounded, unless immediate - "We are doing a good job"

Background, Remote - "We are experts" (April 8th, 2011: 14:40).

This is also displayed in the way expert nurses communicate and present themselves; especially on rounds. The experienced nurse shows more confidence in his/her approach in the care of the patient. Experienced nurses tend to ask for the type of patient they want to care for. There is a certain status gained by looking after certain types of patients - for example, cardiac patients. Traditionally, post-operative cardiac patients are more acutely ill than the rest of the patients in the PICU. Caring for these patients indicates to the rest of the 'world' that you have moved into a different realm, you've joined a new club, the inner sanctum; you have achieved a certain status. Once this level of expert status has been reached a certain amount of kudos is

expected and accepted. **Participant 22**’... *There is no question that there’s that feeling that the cardiac is the be-all and end-all and all the others are secondary ... I think especially because I still see differences, especially with more senior nurses whose ultimate goal is they could choose just to have the cardiacs, ... these kids are terribly sick in the beginning so there’s that understanding that the more experienced nurses will take those patients.*’ **Participant 4** describes a degree of admiration for the concept of belonging to the PICU team. She feels she is not really part of the inner sanctum but loves the energy in the PICU. *‘I love it. I love the energy down there; all the staff are so dynamic. Even coffee time, the conversation, people are interested not just in their work but in what’s going on in the world and outside. There is a heightened energy there ... It seems to be made to support you to look after your patient. You’re not pulled in every direction.’*

Entering the Inner Sanctum

The ICU is the pinnacle of practice in any hospital as it is the gate to advanced medical treatments and technology, treating the most acutely ill patients in the hospital – it is the ‘Inner Sanctum’ (*See Appendix I*). An intensive care unit tends to be a closed unit. That is, one has to gain permission to enter. This is not just for families but patients go through a rigorous assessment or suffer a crisis before they are admitted to PICU. The unit tends to be on the ground floor or on a floor where there is no other wards. Thus it is isolated not unlike the isolation an island and islanders experiences. However, the concept of the inner sanctum cannot be summed up by place alone. It is a culmination of place, people and the culture that develops around both.

The expert nurse has a different type of relationship with physicians. Intensive care nurses work remarkably closely with medical staff. Many intensive care nurses hold similar status to physicians (Seymour, 2001). This would appear to be due to IC nurses’ clinical acumen and ‘medical’ orientation to care, that is; knowledge of both patho-physiology and technological machinery (Lynaugh and Fairman, 1992). There is a significant training program for all health care specialists to prepare them to work in the ICU. PICU adds an extra component of speciality and knowledge. All of these components tend to exacerbate the notion of power and the notion that

knowledge is power and can overcome power, as is suggested by Carspecken (1996). As examined in Chapter 2 and 3, this is an excellent example of how power differences are shaped by knowledge, and of how knowledge supports the democratising of relationships (Belsey, 1983), and can aid to equalises power imbalances.

The Team: Almost all participants described a team approach to care in the PICU. This team consisted of both medical and nursing staff, and occasionally allied health staff. Team members are trusted and considered to be experts in their field of practice. There is a general expectation of independent practice for participants. Participants describe an acceptance of this type of practice from their medical colleagues. They believe this strengthens the 'team' concept as it is seen as a display of mutual trust and respect. The participants enjoy the degree of autonomy they are afforded in the PICU, the ability to make independent decisions, collaborate with doctors on patient plans, and debrief with their colleagues, as the following two quotes attest. **Participant 21:** *'Probably because I know it. It's comfortable, I know it, I'm at a different stage in my life now ... But I know it. I feel that I know it, I feel safe here. I feel like I provide safe care. I feel comfortable asking people for help.'* **Participant 26** also describes the concept of respect afforded a nurse once he/she has gained expert status. *'I think we're such a specialised unit and the more that you're there, the more respect given by the doctors and I think you definitely get more, so I think that also helps as well where you work with specific people. They get to know what you can look after and they start to respect you, they start to respect your opinion, what you're saying is exactly what they're seeing ... you have been proven to be someone who is reliable and this and that, and says what you have to say... they're gonna respect you.'*

Participant 19 describes the more inclusive concept of the team, especially as an expert nurse in PICU. *'Who makes the decisions on rounds? I was thinking earlier that the difference between being an experienced nurse, ... on rounds the physicians trying to decide what medications they should turn down, ... after I felt really comfortable with the patient, four hours later I was able to help the physician make the decision to "let's turn this off". He doesn't need this, he doesn't need that. So we*

together as a team make the decision.' **Participant 15** displayed the feeling of 'just being' in PICU when asked why he stays in PICU. Like others, this participant describes a degree of belonging and comfort with his expertise and place in the PICU. *'I keep asking that myself. At 51 it's getting harder and harder to imagine working elsewhere....I don't feel like recycling myself again, pretending, you know, you have to pretend, you have to put on a show when you're in a new work environment and here I can be just who I am. People accept it in that sense. I don't tremble before coming to work. I don't think 'Oh God'..... That's the main reason I stay.'*

As a member of the inner sanctum (the team) he/she has a certain expectation that the medical staff will show a degree of respect towards their team members which leads to the development of a mutual understanding. This is usually displayed by the attention the physician pays to what the nurse says and how the physician responds to the suggestions made by the nurse. **Participant 17** describes a negative encounter with a member of medical staff but assumes his/her 'ignorance' is because the physician is from another area than the PICU. The nurse expresses her disdain for physicians who do not show the appropriate respect for nurses in the PICU. *'... those I've had negative experiences with have all been adult anaesthesia resident; not all of them, some of them have been fabulous, but certainly could it be the culture of where they come from, could it be what is an expectation or an acceptable behaviour from where they come?. Whereas here that's not acceptable, we're all a team, we all work together, work closely together. If they're not used to an ICU setting, if they're not used to the environment that we have... they learn fairly quicklywhat is acceptable behaviour and what's not.'*

An interesting component of teams is debriefing and where it usually takes place. Participants say that debriefing occurs in the coffee room or after work, usually with a negative tone but with a positive outcome. This is often seen by management as idle gossip and negative, destructive behaviour (Bensahel, 1974; Danziger, 1988; and Zaremba, 1988). Is it malicious? It would appear to be a peer counselling session, which aids in debriefing the distressed nurse. In fact the physiological responses studied in women show that they release oxytocin when they express emotions

verbally, thus improving their mood (Fiske, Gilbert & Gardner, 2010). Gossip usually occurs in a private, intimate environment with friends and acquaintances (Ayim, 1994; Bergmann, 1993; and Suls, 1977). Rosnow and Fine (1976) suggest that gossip performs an important bonding function by dealing with issues of interest to an individual or small group. The evidence provided by these interviews is that these somewhat public (in a professional sense) debriefings may be a very functional component of nursing behaviour.

Participant 31 describes this as follows: **Researcher:** *'How do you deal with those residual emotions?'* *'My bike ride home at the end of shift I find quite helpful. And then ... I get to chat with my boyfriend. My friends in Vancouver are people I've met through work. So oftentimes there will be some venting sessions when we go out or in the coffee room and that helps too.'*

Role Contradictions and Conflicts

Within any work environment there is conflict. In the PICU several conflicts and contradictions have been identified. These elements of PICU are discussed under the following headings: Lack of Control, Growing old, Isolation and Being Held Hostage. It appears that many of these conflicts and contradictions arise from the changing role of nurses and the ceaseless changes in medical treatments and hospital administration. Geographical location is also touched upon at the end of this section.

Lack of Control: Lack of control over his/her surroundings disrupts the nurse's concept of belonging and can lead to moral distress. There are many events in the PICU that can invoke moral distress. The most openly discussed issue is new or experimental procedures being performed on children who appear to have very poor outcomes. Nurses have described some treatments as 'torture' and 'cruel'. They describe these treatments as cruel to both child and parent. There is an intellectual understanding that all of the procedures we perform now may once have appeared similarly cruel to a nurse 20 years ago. However, this pragmatic argument does not change what the bed-side nurse in PICU feels when some of these more dramatic or new procedures or treatments are performed. **Participant 15:** *'I guess I do have an issue with the ethics behind how far we should go. Now I know that in some cases,*

trisomy⁶ 21's can function and can have a life. If they're attached to an extremely complex heart that ECMO⁷ I think that we always offer more aggressive treatments. I think that is what bothers me.'

Almost all participants noted that continued changes in their work environments, for example where equipment is stored in the PICU, changes that occur under the guise of quality improvement and/or patient safety, and perceived to take place without adequate discussion; this caused them a degree of moral distress. This is mainly due to their inability - whether true or perceived - to keep up with the changes to policies and procedures. The main reason that this moral distress is caused by the fact their lack of information might affect patient care. Also, participants felt that if they were not aware of the changes this could be perceived by their colleagues as a degree of inadequacy or incompetence. It threatens their 'expert' status. Participants described coming into work after two or three days off and finding out that significant changes had occurred which directly or indirectly affected how they care for their patient. This was poor communication, as they truly believed it to be; they think that these changes were not being communicated effectively and/or that there were too many changes at one time to communicate effectively. These changes are communicated in writing, verbally, by e-mail posted on the Internet, and an announcement is made at

⁶ Trisomy 21 is a chromosomal condition caused by the presence of all or part of an extra 21st chromosome. It is named after John Langdon Down, the British physician who described the syndrome in 1866. The condition was identified as a chromosome 21 trisomy by Jérôme Lejeune in 1959. Down's syndrome in a foetus can be identified by amniocentesis (with risks of foetal injury and/or miscarriage) during pregnancy or in a baby at birth.

⁷ Extra Corporeal Membrane Oxygenation – An ECMO machine is similar to a heart-lung machine. To initiate ECMO, cannulae are placed in large blood vessels to provide access to the patient's blood. Anticoagulant drugs, usually heparin, are given to prevent blood clotting. The ECMO machine continuously pumps blood from the patient through a membrane oxygenator that imitates the gas exchange process of the lungs, i.e. it removes carbon dioxide and adds oxygen. Oxygenated blood is then returned to the patient. Management of the ECMO circuit is done by a team of ECMO specialists that includes intensive care unit (ICU) physicians, physician assistants, perfusionists, registered nurses, respiratory therapists and medical laboratory technologists who have received training in this specialty.

the Friday updates; but all of these communications still appear to be inadequate to participants.

Many participants described high turnover as causing a state of constant anxiety coming from perceived loss of control. This anxiety was caused by the senior nurse's sense of responsibility, that it was his/her responsibility to supervise the new nurses, making sure that their patients were well cared for and that the new nurse was not left to flounder. It was also reported that the more new nurses that came to the unit, the more the acutely ill patients had to be taken and cared for by the senior nurses. This can often lead to different patient assignment every day: as one patient improves that patient will be passed on to the less experienced nurse and a senior nurse will take a new patient who is more critically ill. **Participant 2A** *'I really was jumping from one patient to the other, and I just like I needed a little bit of break and really to have a more quiet like from that point. So that was part of it ... I think I was frustrated at the time. I know we were pretty short of people so you were always sort of jumping around. You sort of know and understand why they pull you from one to the other and you sort of feel frustrated because I wanted to keep the patient I've just had a good shift.'* **Participant 5A** described this feeling well, when asked why she left PICU. She described high staff turnover and an increase in newly-qualified staff as a significant stressor, leading to burnout. The participant has described a situation in the unit on a day when there was several new staff that were caring for very sick children. The nurse finds this a stressful environment because she does not know how skilled the new staff are and thus cannot trust that these new people are capable of looking after the children. Consequently, she takes on the responsibility of caring for all of the children. *'.....changes with staff. We're constantly having new staff and the burden that the junior staff have on the senior staff; it's huge because we have to carry them. I think we all have become very aware that we're very protective of our patients, whether they're our patients or not that we're directly caring for, we're very protective and that's why we always say 'oh that nurse can't look after such and such' 'cause we're very protective by nature I think.'*

This method of patient assignment was reported by the participants who had resigned from a permanent position in PICU to take a position elsewhere; remaining in ICU as a casual nurse, was one of the major reasons given. This is a very pertinent observation. The author examines the reasons that the majority of people in this study choose to work in PICU: it is for the fast pace, the challenges, the high degree of responsibility, the fact that the area is so specialised that they get to teach junior staff and pass on and display their knowledge. Through the majority of their careers they have striven to attain this almost 'superstar' status of the expert PICU nurses, capable of taking care of patients supported by the most advanced technologies - caring for the child on the edge of death.

However, this leads to an interesting conundrum: the PICU participant nurses strive to attain this expert level and are very resistant to give it up or lose these skills. Yet, it is this very skill that may be creating the 'shock' (Mitchell, Holtom & Lee 2001) that causes them to leave. Participants perceive that their expert status is abused or taken for granted by managers. That is, managers view nurses as a resource there to get a job done rather than as professionals who need a degree of respect and job satisfaction which includes continuity of patient care. Then this clash of views may eventually cause burnout in the PICU participant nurses, since it also gives them the feeling of lack of control. **Participant 26** attempts to describe this conflict. *'I think that the point is I love my job. I like what I do. I think we don't have enough bedside nurses with senior experience and I've gotten a couple of compliments from doctors that were really quite impressive. ... So at this point there's no point in me leaving ... I don't wanna leave this unit yet. I'm proud of what we do, and even the skill set, ... all these skills you have, it's huge... it's quite surreal what we do and I think that we don't really fathom it. To the same level, I think we are always under constant stress. What we do is at such a high level and I thought oh well, and I think to go anywhere else I would lose those skills, I don't wanna do that yet.'*

Floating to other wards when the PICU is quiet appears to cause a degree of outrage and upset to the participant nurse. For example **Participant 6** describes a situation where she was forced to float because it was her turn, even though she had been caring for the same patient who was end-of-life for the last three days. The emotional

response is profound. **Participant 6:** *'I had worked the previous day and I was primarying⁸ a patient who was an end-of-life patient, and I got moved the next day when I came in. That created the reactivity in me right away, I went (floated to the ward), but I'm a primary, and I was here yesterday. At that point they were not going to change the assignment, I said I was leaving. I know I wasn't, I just became reactive in that moment. ... To me, I'm here for the child. I'm here to continue to do the best possible care that I can. And part of the possible care is actually continuity. I felt there was no continuity and I couldn't quite get past that ... I knew I had to go upstairs. I think the biggest thing is I wasn't heard. I felt I wasn't heard.'*

Participant 21 felt offended and that this idea of floating was an insult and displayed a lack of respect for her level of training and her status as a PICU nurse. She describes: *'It also can be a really difficult place to be..... it feels devaluing....the floating thing, that's always a huge demoralization. We just are not ward nurses, and it's a big deal... I understand what the hospital is doing, but until you walk in our shoes, we aren't a nurse is a nurse is a nurse. It just isn't that way. There are so many things in place that point to us as being a specialised field, and then all of a sudden we're just well off you go...'*

Growing Old: The current age of the registered nurse workforce indicates that the average age of registered nurses in developed countries is 44–45 years of age and projected to rise over the next decade (Kingma, 2006). This is consistent with the average age of the study's participant nurses. The more senior nurses described a certain degree of physical fatigue due to age. They felt that this was particularly prevalent when they had to do night shifts. And they believed that one of the reasons they would leave ICU would be to take a position that does not require night shifts. They also described their experience of night shifts, not only from the perspective of sleep deprivation, but the effect that sleep deprivation has on their health in general. This concern is well documented in the literature (Muecke, 2005). Participants found that night shifts interfered with appropriate diets and exercise. Senior staff believed that there should be some concessions made for them by the employer when it comes to night shifts, floating in other areas of the hospital and patient assignment.

⁸ Primarying is a term used when a nurse signs up to take the same patient every time he/she comes to work for as long as that patient is in PICU.

Participant 21 describes how she believes more experienced nurses should be treated as they grow older. *'And I think that there needs to be some recognition for people as we grow older; I think you would retain your staff here, with the option of day lines, period.'*

Older participant nurses also expressed their dissatisfaction with the leadership in ICU mainly due to what they believed to be a lack of loyalty or support for them as senior staff. They do not believe that the management team values their input into PICU and they believe they have very few rewards for their years of service. Although they complain of this concern and complain about management's lack of interest in them, they have not described poor management as a reason why they may leave the PICU directly. Although they say they would like more recognition from management they consistently reported that they put more value in the opinions and support of their peers in PICU and their medical colleagues than in that of management (Henderson, 2001). The nurses do describe a lack of leadership as stressful and they believe they are often left to flounder due to this perceived or real lack of leadership. This is consistent with the literature (Boyle et al., 1999). More experienced participants identify this lack of recognition but remark that peer appreciation is more important. **Participant 12:** *'You don't want your colleagues to think that you're not good enough to take care of that child, or you don't do a good job, everyone wants to think that people (a) like them, and (b) think that they do a good job. Maybe it's down to the basics of human nature..... I want them all to think I do a really great job here.'* **Participant 30:** *'I feel recognition from my peers and from the families – which is huge. I don't feel recognition from my leaders, but that's (family and peers) enough recognition for me.'*

Isolation: At one time this PICU functioned in nursing teams with set schedules and set leaders and set team mates. Approximately seven years ago (in 2004) the unit changed to self-scheduling⁹. It is when nurses describe the feeling of isolation that they become nostalgic about the idea of teams and question the wisdom of self-scheduling. Although the majority agree that they enjoy the freedom self-scheduling

⁹ Self Scheduling refers to a system where the individuals choose what shifts they work, and in what order. There are guidelines to follow but generally people have the flexibility to design their own schedule.

affords them, they regret the loss of peer support and the degree of teaching, nurturing and true friendships that were developed during those specific team years. That is, nurses appear to experience the joys and challenges of teamwork, but regret/fear the sense of isolation that has been increased by the loss of the nursing team structure. **Participant 13:** *'I find that is the culture around ICU. I don't find that it's like a team, I feel that it's like segregated divisions, there's nursing, there's housekeeping, there's the unit clerks, there's the medical staff, and then there's the staff that come from outside of the unit.'*

The aspect already described by the participants in the inner sanctum is isolation, be it physical (location in the unit) or psychological (being on the unit with nurses you do not know). Most participants describe this type of isolation in the PICU. In the author's field notes she identifies this aspect of ICU. When describing both the physical layout of the PICU and the fact that each nurse has one patient; although the patients are side-by-side, the intensity of their illness tends to be all-consuming. Thus, each nurse tends to focus on her own bed-side and patient, becoming somewhat immune to the activities in the rest of the unit (see *Appendix D*).

Being Held Hostage: Another aspect of the PICU and PICU nursing is a limited amount of units in any city. In Canada the majority of cities have one PICU, although this differs in some of the large American and British cities. Due to the small Canadian population (33 million approx.) one PICU per city is surfeit. This does hold the PICU nurse to ransom in that if he/she wants to work in any other PICU they would have to change city, province or country. **Participant 7:** *'I've grown to love this city, I've been here for five years now and I could potentially say that the city kind of also keeps me maybe a little, really draws me to stay here. It being the only PICU in the province.'* **Researcher:** *'What keeps you here?'* **Participant 29:** *'It is stuff like that, it's very rewarding to be able help the family, and they were very appreciative of the fact, it keeps me going. And like I said proximity, I live very close to here. I really do like the paediatrics ICU and there's really not another one anywhere close.'*

This geographical confinement is difficult for staff especially when he/she has a family or when a nurse has developed a specific lifestyle and social life in a given city. This could possibly be an additional reason nurses leave the PICU. This may foster a level of confinement or professional stalemate. The inability to progress professionally or expand their experience or horizon without a significant life change may very well cause nurses to change their career path from PICU to a more easily accessible and opportunity-driven area of nursing.

Summary

In this chapter the author discussed some of the key influences on the PICU nurse and why the influences were found to be important. The data collected in this research reflects PICU nurses' perspectives and how their environment may influence their decisions to stay in or leave PICU. During the analysis the author discovered that there is an over-arching theme or influence on PICU nurses in PICU: the complexity of caring. Also described are the most important environmental/cultural influences identified in this research: becoming an expert PICU nurse, undergoing peer review, entering the inner sanctum, and role contradictions and conflicts.

Becoming an Expert PICU Nurse and Peer Review: Analysis shows that becoming a PICU nursing expert is a process. Peer review was seen as one of the most important aspects of being accepted in PICU. It was seen as a positive monitor of skills and expertise, while the nursing management group's opinions were seen to be negative and to a degree an abuse of power, often seen as favouritism or at least subjective judgments.

Entering the Inner Sanctum: The concept of arriving, being an expert, being seen to be an expert and being considered part of the team was categorically the most influential component of what keeps the PICU nurse in PICU. The environmental influence that is most profound for this idea of team and belonging in the PICU is respect.

Role contradictions and conflicts: The conflicts and contradictions found in the PICU environment are described from the nurses' perspective and using the PICU nurses' voices. Their responses, using their own words, help to validate the findings. In Chapter 5 the theories supporting these findings are discussed.

CHAPTER 5: DISCUSSION

Introduction

The findings from the researcher's critical ethnographic analysis were shown in Chapter 4. Here the findings are presented in light of existing literature in order to locate them in a broader field of knowledge. New insights will be presented from the PICU nurses' perspective. There is a very limited body of research regarding PICU nurses and the factors that influence them with regards to retention in the PICU (Bratt, et al. 2000; Foglia, et al. 2010). Thus, this work should be considered exploratory research. The findings show us that becoming a PICU nurse is a process. The researcher has established that becoming an expert PICU nurse is of prime importance to the PICU nurses' sense of achievement and job satisfaction. While analysing the data the author was struck by three central tenets that appear to have an overarching influence on the PICU nurses' environment. These key elements of PICU environment are: Trust, Communication and Burnout. First, the author will discuss how trust is fundamental to the process of becoming an expert PICU nurse. Following this will be a review on how burnout and the elements of burnout (Emotional Exhaustion, Personal Accomplishment and Depersonalisation) impact upon the expert nurse. The author will then consider how communication and communication styles affect the process of becoming an expert PICU nurse. The researcher reflects on death in the PICU and FCC. Finally, both the traditional causes of attrition and the reasons why some nurses' stay in PICU for many years regardless of their own mental or physical health will be considered.

This research is informed by a critical social perspective. In Chapter 3 the concepts of critical theory were discussed and why this theoretical lens provides a suitable base for this inquiry into PICU nurses and how their environment may influence their decisions regarding working in PICU. As this research is based on a critical ethnography methodology, power and power imbalances are ongoing considerations. Critical Ethnography and Power are described in depth in Chapters 2 and 3. Browne (2000) notes that all social constructs are inherently built on power imbalances. Participants appear to have a natural understanding of the power in the PICU; most of the time they describe it as a lack of trust rather than power.

The Centrality of Trust

Trusting and being trusted is fundamental to becoming an expert PICU nurse. Consistent with the literature (McKnight and Chervany, 1996) when discussing trust, participants described it as a necessary component of successful teamwork; participants felt they needed to trust their colleagues' abilities to look after the patients. If this trust was not there, participants described a deep level of stress and agitation at having to take on the added responsibility of a less experienced nurse's patient. Participants described trust as 'trusting and being trusted', as opposed to 'not trusting and not being trusted'. In fact, most participants described it as a necessary part of their jobs and described a lack of trust (in their colleagues' skills or abilities) as a significant stressor.

As discussed in Chapter 4, this creates a power difference between senior/expert nurses and junior/novice nurses. This may be a power imbalance but there is no evidence from the participants that it was considered an abuse of power. This is consistent with the author's field observations. The reference that follows from her field notes describes an observation of an interaction taking place in PICU and a deconstruction of that interaction by the researcher. In this interaction the junior nurse asks for assistance from a senior nurse who is busy at that moment. *'There are two ways to interpret this interaction. Initially the observer wondered whether this was a power play between junior and senior nurse but on paying closer attention to this interaction it became apparent that the senior nurse had learnt to complete each task that she had started unless interrupted by an emergency patient-related issue; otherwise she would spend her time running around in circles rather than completing her work, thereby placing emphasis on the significance of each component of her work. This was more obvious when she went to help the junior staff member understand the cardiac defect. She praised and reassured him while having an interactive educational session. This reinforces the idea that this nurse believes the education of junior staff to be important, and a very definite part of her job.'* Here we can identify how the nurse is being socialised to the PICU or the *field* as described by Bourdieu in Bourdieu & Wacquant (1992).

The broad concept of trust is discussed throughout this thesis. It appears to be one of the main environmental influences on participants' level of job satisfaction and thus on their intentions to stay in or leave PICU.

Using a critical ethnographic lens, this researcher concludes there are power imbalances. However, to concentrate solely on power would be to neglect the more fundamental reasons for these trust issues. She is conscious of this context, and spent much time reflecting and discussing the reasons for her findings with colleagues and supervisors.

Burnout

The theory surrounding job satisfaction and burnout has been studied extensively. In Chapter 2, the literature on burnout was discussed (Maslach, 1981). This study has confirmed many of the findings from previous research. The participant nurses reported the stresses, strains and joys of caring for children in the PICU. In the literature, the emotional, mental, social and physical features of caring have been described. Nurses, teachers and managers are groups of employees who are likely to report high levels of workplace stress (Smith, Brice, Collins, Matthews & McNamara, 2000). There is evidence to suggest that ICU nursing is a particularly stressful specialty of nursing (Adomat and Killingworth, 1994; Donchin and Seagull, 2002; Hurst and Koplin-Baucum, 2005; Lally and Pearce, 1996).

Maslach & Jackson's Burnout Inventory (MBI) (1981) was designed to measure aspects of the burnout syndrome. *Table 1* refers to the inventory subscales associated with burnout.

- Emotional Exhaustion
- Personal Accomplishment
- Depersonalization

The findings in this research are located in these subscales. However, as discovered in chapter 4 PICU has several significant deviations from the subscales as will be expanded below:

Emotional Exhaustion: The main issue described by those participants who have left their permanent job on the PICU but remain in a casual position, is a significant component of stress or burnout (Group 1a – 5a). In fact they identified it as the main reason they left PICU. As discussed in chapter 4 this exhaustion was not caused by the physical requirements of the job or by death or the added component of caring for families. It was caused by the increased amount of responsibility placed on the senior staff when there are unqualified or more too many junior staff on a shift.

Personal Accomplishment: The process by which nurses' shift from *outsider* to *insider* may be one of the most remarkable themes that developed over the course of the analysis from both the interviews and the researchers' observations. This sense of identity became obvious in the discussions, as nurses spoke of their experiences and their colleagues. Maintaining expert status appears to be paramount to the PICU nurse. This status demands a degree of respect that needs to be understood by managers and administrators. In this facility nurses from the PICU have been forced to 'float'¹⁰ to other units if that unit is short of nurses. Expert nurses view this as an insult and a lack of respect for their expert status. Most Paediatric Hospitals in North America advocate the philosophy/concept of family-centred care. At least they support it in theory; often many of the actions or demands of administration, such as floating to other units if the PICU is quiet, and doubling patients if there is not enough staff, undermines the sense of team and belonging that is fundamental to retention for the PICU nurse. While Family Centred Care (FCC) facilitates participant job satisfaction there is a contradiction of the hospitals' own strategic directive of FCC. Nurses are encouraged to become primary nurses for patients who are in PICU for more than a few days. The concept of FCC is heavily endorsed and yet discarded by managers in order to facilitate floating, and administrative operative expediency is imposed upon nurses. This can be described as professional stereotyping. That is, 'a nurse is a nurse is a nurse'. To understand the impact of professional stereotyping can be understood by considering Mintzberg's theory as

¹⁰ Floating refers to the practice of moving nurses from one unit to another to balance out staffing numbers. It is based on the principle that a nurse is a nurse is a nurse.

discussed in Chapter 2. This theory is supported by the reaction of participant nurses to the practice of floating PICU nurses to the wards.

Participant nurses have described floating as an insult to their expertise and a lack of respect for their position. This could act as a 'shock', as described in the literature related to job embeddedness (Mitchell et al. 1999, 2001) that might cause a nurse to leave PICU. We have established that ICU areas are vulnerable to staff turnover and shortages (Cartledge, 2001; Daines, 2000) and yet some nurses are able to thrive in the ICU environment and maintain their enthusiasm for their work despite the stresses. However, others become distressed, resulting in high sickness, absence, poor staff retention and ill health (Chiumello et al., 2000; Healy and McKay, 2000; Norrie, 1995; Shader et al., 2001; and Wheeler, 1997). Bryant (1994) suggested that some nurses are tougher or harder than others, and exhibit beneficial personality characteristics which shape nurses' adaptation to the ICU. Burgess, Irvine & Wallymahmed (2010), note that certain personality traits may affect an individual's perception of stress. They indicate that ICU nurses do not significantly report high levels of stress. One explanation for this could be the work environment that is nurtured in ICU. As demonstrated in this research, PICU nurses are afforded more autonomy and PICU nurses often enjoy good working relationships with their colleagues (Nolan et al., 1995; and Volk & Lucas, 1991). Thus, they are able to have a degree of control over their working environment and hence reduce their perceived workplace stress (Nolan et al., 1995; and Volk & Lucas, 1991).

Burgess et al. (2010) study provides evidence for the value of ICU nursing experience. The higher the number of years of experience, the lower the level of perceived stress from these constructs. It may be that nurses learn to deal with the external stressors over a period of time in the ICU, and familiarity with the ICU environment moderates the perception of stress. Burgess et al. suggest that certain personality traits; such as being extroverted, influences a nurse's ability to cope in the ICU. Tummers et al. (2002) found that ICU nurses had lower levels of emotional exhaustion compared with their ward-based colleagues; they concluded that their unexpected finding may be attributable to the personality traits of the ICU nurses. The positive effect of venting was revealed in a recent study by Bosson, Johnson &

Niederhoffer (2006), they concluded that sharing negative attitudes (venting) had a positive effect on the nurses. Venting may be a strategy that ICU nurses use as a means of coping and avoiding stress. While this study supports the finding of much of the research above, especially the value of experience and venting, the author did not find any evidence to support the concept that personality traits are influential in a nurse's desire to stay in PICU.

Hochschild (1983) in *The Managed Heart: Commercialization of Human Feeling* described Emotional Labour (EL) as a requirement of employment in many professions. Hochschild defines EL as '*the management of feeling to create a publicly observable facial and bodily display*' (1983: 7). She uses the study of flight attendants while illustrating the concept. Hochschild's '*search for authenticity*' (1983), involves the display of emotions that are not just polite but appear genuine even under the most challenging circumstances. Hochschild notes that there is a personal cost in performing in such roles, where the ability to display genuine emotions must involve the 'self'. Smith (1992) and Froggatt (1998) applied this concept to nursing. Nurses' willingness to engage also appears to vary according to the opportunities and encouragement within particular work settings, to develop strategies for coping with emotional situations (Henderson, 2001). Henderson believes that this is a '*high-level skill and one which requires great honesty, tenacity and perseverance. Not surprisingly, such a high degree of personal investment can have both positive and negative effects*' (2001:136). This study has shown that FCC can help to mitigate some of the negatives surrounding EL, as nurses are afforded the time to indulge in EL.

Depersonalization: Nursing has taken on a great deal over the past century.

Meadows, Levenson and Baeza, (2000) noted: '*Throughout the research, we noted that nursing was attempting to combine traditional, caring elements with expanding roles that would have been the province of medical staff not so long ago. For some nurses, this is a welcome development, permitting the best of all worlds and enabling holistic, person-centred care to be delivered with expertise and technical competence while also providing intellectual challenge and fulfilment. For others, changes and*

expansion to the nursing role represents a threat rather than an opportunity, at least within current resource levels.’ (2000:14).

It is important to look at the concept of moral climate or the workplace environment in which the nurse has to practice. The moral climate of nursing is best described by Patricia Rodney (Storch, Rodney & Strzomski, 2004) *‘By ‘moral climate’ we mean the implicit and explicit values inherent in nurses’ workplaces. Those values operate at individual, organisational, and societal levels and affect the structural and interpersonal resources available for nursing practice.’ (2004: 216).*

When participants discussed moral climate it was usually in reference to extreme medical treatments, or extending life when it was considered futile by staff. Nurses have become more and more frustrated with their workplace (Meadows et al., 2000). They feel they are not being ‘heard’ and, more importantly, they do not have the time or facility to do their jobs in a professional, safe manner. This can lead to moral outrage. *‘Anger and frustration at poor facilities were surpassed by widespread concerns by nurses who felt that they were unable to carry out the jobs for which they were trained because of a range of factors, particularly budgetary constraints or organisational problems. ... These findings were consistent across the literature and the fieldwork.’ Meadows, S., Levenson, R. and Baeza, J., (2000:33 – 34).*

The negative work environment created by this situation can only be detrimental to nursing’s moral climate. Barbara Reinold (1996) put this in the perspective of negative cultures in the work environment. *‘Toxic work situations sap your energy ... then the insidious eating away of energy and self-esteem begins in earnest.’ (1996:16).*

Communication

Communication was a significant theme throughout the interviews. An interesting observation by participants was how their method of communication changed over time. Several participants noted that the way they expressed themselves changed from when they started in the PICU as junior staff members. They described this

process as taking several years. They mainly described this as a change from a subjective to a more objective form of speech. There was also a confidence and assertiveness that comes with the acquisition of knowledge and skill. Some participant nurses believe they were schooled to communicate from the counsellor or listener perspective, while physicians are thought to communicate very objectively – using the medical model. The documentation and discussion of facts is the predominant component in this medical model, and the concept of feelings or psychosocial aspects is of lesser importance. However, this has changed over the last twenty years (Harden & Crosby, 2000). This has brought up some interesting reflection: traditionally medicine was male dominated, while nursing was female dominated.

Communication and communication styles became a significant part of peer review. The difference in communication styles raises many questions: are nurses and doctors trained to communicate differently?

Where did this stereotype come from? Is it an effort to gain power over nursing, health care and women? The founder of nursing, Florence Nightingale, was far from any of these stereotypes, and the first nursing students were generally of a certain stratum in society – usually upper middle class. Florence Nightingale was also a gifted statistician (Ettinger, 2009). However, Miss Nightingale did equate good nursing with proper, white, middle-class womanhood, claiming that good women/nurses should be submissive, dependent, and self-sacrificing (Malka, 2007).

The majority of participants in this research project described their jobs with pride and state that they are happy in the environment most of the time. Interestingly, it is not really the work itself nor the stressful nature of that work that would cause a nurse to leave, but more external issues over which they feel they have no control; or they recognise they are aging, and nights and shift work are becoming more difficult.

Death and Family Centred Care (FCC)

The concept of death and how PICU nurses perceive death appears to differ significantly from nurses working in other areas. The majority of the public do not consider death good at any time, and the literature supports the idea that there is no

such thing as a 'good death' in hospital. Moskowitz and Nelson (1995) note that the attitudes towards modern illness, treatment and death are viewed as a paradox: while patients come to hospitals to stave off death they have a fear of the hospital death, assuming it will be overly medicalised and lack dignity (Seymour, 2001). Hospitals are the place of death for the majority of people in developed countries (Griffin 1991). Timmermans, in his work on hospital staff's approach to resuscitation, notes that certain social characteristics of the patient have moral connotations that affect how the resuscitative effort will go. The most important of these characteristics was age and the perceived outcomes of the particular illness (Timmermans, 1999). This suggests that death in the PICU must evoke a different response from the nurse than that in the adult environment.

Seymour (2001) suggests that it is the meaning of technology that determines the 'good death' in ICUs. She believes that how technology is employed by the clinical staff affects the concept of death in ICU. She goes further to add that open communication and trust are keys to the perception of the 'good death' for families. This concept supports the author's findings in the PICU under study. It also supports the expanded meaning of FCC. The majority of participant nurses believe that the experiences of death that they have observed have been uniquely spiritual and 'good'. The nurse explains this by his/her ability to encompass the family in the process of the child's death. The PICU nurse is there as the support – the pillar to lean on. These nurses can facilitate any reasonable request to allow the family to feel this is a good experience. They express their own natural sense of grief later and openly, thus avoiding any possibly negative psychological effects the death could have on them.

The literature has encouraged the adoption of a FCC approach in paediatric hospitals in North America. This approach is supported not just by the health care providers but also by administration. This shift in philosophical approach to care in paediatrics supports staff in providing this type of care. This type of care tends to take time. However, in all of the explanations and definitions of FCC there is no mention of the health care worker and the effect FCC may have on the carer. As discussed in Chapter 4 the effect of FCC can be both positive and negative.

The participant nurses feel that they always practice FCC but know how to balance it. They may also feel threatened a little in that the power balance between the nurse and the family has shifted to a more even standing. However, this concept warrants further research. It may be time to elaborate on the philosophy of FCC. The dominant discourse on FCC is taken to mean so many things. As it stands it does not encompass the true underpinning of the type of care it attempts to describe. The author suggests more precision in framing the concept of FCC to include nursing/physicians/allied health engagement in the care of the child, especially in an area like the PICU. The types of relationships forged in this highly acute area are unique. FCC does not describe the authentic engagement with families that nurses describe. This type of care may be unique to the PICU, which affords the nurse the time to care for one patient at a time, thus allowing the nurse to encompass the patient's family as part of the care plan. FCC is closely linked to the concept of emotional labour.

This research has uncovered the fact that FCC is supportive of the nurse's ability to conduct his/her work; in the underlying philosophy that support means taking time to spend with families and the patient. The carer is encouraged to spend time talking and discussing care with the families. This is indeed a shift from 50 years ago when nurses busied themselves with non-nursing duties such as stocking linen rooms and shelves. FCC philosophy does not encompass, nor does it place merit on, the value the health care worker gets from this vital engagement with families.

Summary

In this chapter the author discussed the literature supporting the findings of this research and why they are important to the PICU nurse. Nurses identified these influences as having the most impact on their ability to work and stay in PICU. By using critical ethnography she presented a new perspective on the experience of PICU nurses. As an 'insider', using interviews of PICU nurses and conducting unobtrusive observation, she has been able to identify their perspectives on their work environment. These perspectives have shed light on their expectations of their work environment. Working in the PICU for these nurses is not just a job but a career. They strive to achieve expert status and once this is achieved they believe they are a member of a team, which brings respect and admiration from colleagues and the public alike. Anything that interferes with this perspective, such as floating, can cause significant upset and create the 'shock' as described in the theory of job embeddedness that causes them to leave this environment.

In the final Chapter the author summarises the thesis and discusses the limitations of the study. She also suggests implications for policy and practice, and future directions for research.

CHAPTER 6: CONCLUSIONS

Introduction

This final chapter summarises this thesis and includes some reflections on the process. The findings document some of the cultural features of PICU nurses' work environments. The thesis provides insight into possible methods to influence this environment and insight into nurses' decisions to stay in or leave the PICU environment. This could enhance the organisation's capacity to shape the PICU into an environment which will attract and retain PICU nurses. The limitations of the study are presented; and the implications of this study for policy and practice and how this research has potential impact on recruitment and retention of qualified PICU nurses.

The research process may assist nurses to understand the social and political features of their practice contexts, opening new avenues for them to actively influence their work environments. Increasing nursing engagement could improve patient care and patient outcomes in the PICU. Suggestions for further research are explored. There are several projects that should follow this exploratory research.

Thesis Summary

The environments in which nurses' work unfolds have been the site of extensive research. This has focused on the complexities of nursing practice. A number of qualitative research methods have been used, including grounded theory, naturalistic inquiry, ethnography, and phenomenology. These methodologies draw attention to specific aspects of nursing care which are of importance to health care practice. However, these methods did not provide the specific tools needed to explore the challenges of power imbalances and the experiences of inequity that many have identified as important influences on nurses' work. This thesis explores the potential contribution of one specific methodology – critical ethnography – to the inquiry into nurses' work environments and nursing work. A qualitative study involving over 20 hours of unobtrusive observation and 31 PICU nurses is presented and analysed. There is a limited amount of literature on the PICU nurses' work environment; thus it is suggested that this research should be considered exploratory in the field of nursing research.

Wall (2010), notes that more critical research about nurses' work is needed. She adds that knowledge and professionalization are important concepts and '*can provide new perspectives for deeper questioning about nurses' work experiences.*' (2010: 145).

As a methodology, critical ethnography brings a particular focus to qualitative inquiry, drawing attention to issues of equity and power. This research explores the usefulness and some of the complexities of critical ethnography as methodology, with particular attention paid to what the methodology brings into focus and some of the complexities of this approach to inquiry. Critical social theory sees the world as something that has to change (Bryman, 2001). Ontologically, it involves criticising and supporting change based on the interrogation of a phenomenon (Bryman, 2001). The ontological and epistemological values of Critical Social Theory upon which CE is based accurately reflect the data found in this research project and support the key environmental elements affecting job satisfaction as described by the nurse participants in the PICU.

During the semi-structured interviews, participants were at ease and spoke freely and in depth about their experiences. It became clear during analysis of the data that the issues of power and respect are crucial to the PICU nurses, to their level of satisfaction with their job, and to their intention to continue in that role. Critical ethnographic analysis demonstrated that PICU nurses expect to develop expert status. Centrality of trust, communication and caring were found to be fundamental influential factors that affect nurses in the PICU. They believe that with increasing knowledge and practical expertise the nurse elevates himself/herself to an equal footing with the other health care workers involved in PICU patient care, especially physicians. The findings elucidate the process by which nurses' progress from novice to expert in PICU. This is a process that gives pride and satisfaction to the individual nurse. It became apparent that nurses like milestones to indicate different levels of expertise.

This study confirmed that the PICU environment has similarities to the general adult ICU environment, with one major exception: the philosophy of caring is significantly different. This is presently termed as 'Family Centered Care' (FCC). This research

has shown that the terms and philosophy surrounding FCC is too limiting to really encompass the practice/philosophy of health care workers in the PICU.

The impact of patient death on the PICU nurse, while distressing, does not appear to cause severe moral distress, and in fact it may be one of the more satisfying components of the job. Due to the fact that the nurse has time to spend with the family and the dying child, he/she is encouraged to make the experience as tolerable as possible for both patient and family. This is also an aspect of FCC. The philosophy of care in the PICU is one which supports the care of the patient plus the immediate and even sometimes the extended family throughout their stay in the unit. The nurse is encouraged to take the time required to fulfill this role. The institution supports this philosophy, at least in theory. Often, many of the actions or demands of administration, such as 'floating' nurses to other units if the PICU is quiet, and doubling of patients if there is not enough staff, undermined the sense of team and belonging that are fundamental to retention of the PICU nurse.

The extent of the impact of emotional labour on PICU nurses is not well understood. Henderson (2001) believes that: *'Understanding the emotional demands of caring work may be one of the most important steps toward retaining many of the nurses we have by recognizing the enormous contribution of the profession to health-care.'* (2001:137).

Polit et al. (2004) have suggested that CE focuses on raising consciousness and aiding emancipatory goals to effect social change. The researcher believes that the participants' very involvement in this research has helped to make nurses more aware of their environment. It is hoped that once the results are published this research will assist the bed-side nurse to voice her/his position and expectations as an expert nurse in PICU more clearly to administrators. Also, this work will translate what was previously considered to be the nurses' opinion to an evidence based perspective.

In identifying both the cultural factors that are satisfiers and dissatisfiers for bed-side nurses working in this PICU environment this research has achieved the aims of this

project. That is; by examining the key features within the cultural context in a Canadian Paediatric Intensive Care Unit (PICU) environment as experienced by nurses, and identifying what these influences are, we can understand how these influences shape nurses' intentions to remain at critically ill children's bed-sides for the duration of their careers.

Limitations of the Study

It is accepted that there are limitations to the study. The concept of the insider status of the investigator and power imbalance has been addressed by the researcher removing herself from her Clinical Nurse Coordinator (CNC) position for a year. The single site, although not unusual in CE, may be seen as a drawback. However, as this study is exploratory the single site is an appropriate choice; but it is not possible to generalise the findings without further research. This does not mean that the findings of this research are not relevant or of interest to those working within PICU settings. Also, the nature of CE demands that the researcher be an *insider*, which dictates that the researcher be very familiar with the environment and the subjects of the research.

Only one site was investigated for this research, reflecting the accounts of these particular participants and their experiences within this site, and the author's interpretation of these accounts. Some of the participants were requested to comment on the data and the author's interpretation of them, as she felt that respondent validation was appropriate for this study. This can be viewed as a limitation if it is considered that individual participants can only consider their individual concepts and not the global perspective. However, it is submitted that the global perspective should be the domain of the researcher, not the participants.

This research only studied the perspectives of the nurses. The perspectives of the patients, family members and the other professionals involved in the care of children in the PICU could have given a broader understanding of the issues. However, the perspective of others might have diluted the essence of the study, which was the nurses' perspective on their environment and the reasons why they stay in or leave the PICU.

The author was dependent upon enrolment of potential participants, who may have been willing to volunteer, consciously or unconsciously, in order to please the researcher. This emphasises the concept of the insider and power imbalance produced by this scenario. This may be interpreted as a bias in that certain types of nurses were excluded because they did not volunteer themselves as participants. The author had no indication that those being interviewed were under any duress and believed that nurses' were participating in order to have a voice.

All the participants were Caucasians. This reflects the predominantly white population of the nurses in this PICU, and is not representative of the demographics of the Canadian population. Therefore, the ethnic cultural aspects of nurses in the PICU were unable to be addressed.

Implications of this Study for Policy and Practice

This study enquires into the perceptions of PICU nurses as to what it is about the PICU environment that keeps them in this acute, high paced, high stress environment.

Recognition

The author has suggested that nurses attain a certain level of expertise (expert status) and knowledge that allows them to equalise their relationship with physicians but not necessarily with those removed from the bed-side – i.e. hospital managers and administrators. The implication of this is that nurses need further recognition for their achievements from hospital managers and administrators.

The PICU in question is the only one of its kind in this Canadian Province. A PICU cannot function without maintaining a healthy and contented qualified nursing complement. In 2009, as documented by the PICU data records, 137 surgical and medical admissions to ICU were cancelled mainly due to lack of qualified PICU staff. Without this key element in place, children will be forced to seek medical treatments out of the province, which is costly and potentially harmful to the child. The recruitment and retention of PICU nurses is fundamental to solving this problem. Increased recruitment of nurses to PICU has had a positive impact on the

cancellation ratio during 2010. However, it has also increased the number of times PICU nurses are requested to float to other units when the unit is not at full capacity. This research identifies what nurses in this PICU require from their environment and what it is that could cause them to leave PICU. Once nurses have achieved expert status they expect to be treated with respect as professionals. Forced floating appears to be contrary to the nurses' idea of respect for both their profession and their training. This lack of respect for the professional PICU nurse counteracts much of the ground gained by knowledge. The power balance thus becomes skewed by these organisational practices, leaving the nurse in a position where the status and authority gained by becoming an expert in PICU is diminished considerably by established professional identities and gender stereotypes. Floating should be seen as a cause for expert nursing attrition in the PICU, and it must be taken into consideration when hospital administrators are defining hospital staffing policies. This is not to suggest that PICU nursing experts should not be utilised more appropriately throughout the hospital; the efficient running of the organisation has to be taken into consideration. This study supports utilising PICU nurses as a resource for the ward staff, in an advisory, consultant or teaching role rather than substituting ward nurses with PICU nurses.

Education

This study supports previous research findings that PICU nurses experience a journey through novice to expert (Benner, 1984). The majority of nurses interviewed in this research indicated that having educational milestones would allow them to gauge their progress, thus implying that a structured educational plan is of benefit to the PICU nurse's progress in becoming an expert. For the purpose of retention it would be best that the PICU have a structured system of education, not only allowing nurses to understand their own progress but also assisting in the peer support and education of their more junior colleagues. In order for the PICU nurse to gain expert status, this rite of passage appears to be necessary. That is, a structured approach allows the nurse to have an outward appearance of progression and insight into his/her own progress.

Equality and Power

This study has confirmed that as PICU nurses become experts in their field due to experience and education, thus reducing the power imbalance that exists between PICU nurses and the medical professional; this leads to more equality in the team approach in the PICU. The participants describe this as one of the most satisfying components of their job.

Suggestions for Further Research

The author recommends that a larger-scale study be undertaken to continue this research, by conducting similar studies in other PICUs across Canada. If results from this present study were to be replicated on a larger scale, a greater degree of generalisation and transferability of findings might be possible. Additional research on this topic is necessary in order to create a greater body of knowledge of the PICU environment, and the influence it may have on nursing recruitment and retention.

Comparisons could be studied:

- Are the implications the same for general adult ICU's?
- Do other specialty areas such as oncology and NICU have similar findings?
- A study of other health care workers in the PICU, such as physicians and respiratory therapists would be appropriate, with particular attention paid to how they perceive how the environment affects their practice. This could complement the PICU nurses' perspective. It may also be worth considering how these professionals view the role of the expert nurse in the PICU environment.

Studies involving a wider ethnic and cultural mix of nurses are needed to highlight different expectations of the environment within which they work. However, the author considers the most important aspect of her conclusions - which requires further research - is the concept of FCC. There is a need to change the term to a more encompassing one that will truly capture the essence of holistic care that health care workers provide for children in hospital. An observational study of a multidisciplinary sample of health care workers throughout at least two paediatric hospitals would more fully evaluate this concept.

Summary

The concepts of culture, ethnography and power, and their relationship to nursing research have been discussed in this thesis. The reason that power is relevant to nursing and nursing research is illuminated here, highlighting the importance of understanding the knowledge/power relationship and how we use knowledge to minimise the power imbalances among professions. Overlooking or disrupting this balance by not showing the expert nurse due respect is a profound cause of job dissatisfaction. This lack of respect for nurses' experts appears to be wide-spread, and is shown in the practice of floating (in this instance), thus creating a new power imbalance for the nurse. This is seen as a stereotypical display of the hierarchy embedded in nursing. A critical ethnographic focus aids in opening up these unseen power imbalances and our perceptions of reality. Gaining this type of knowledge will allow nurses to recognise and address any of these issues that may exist in their environment. It would also serve hospital administrators well to take note of this notion if they are to retain nurses in such difficult-to-staff areas.

The findings of this study document the cultural features of these nurses' work environments and enhance the organization's capacity to shape environments which will attract and retain PICU nurses. In addition, participation in the research process assists nurses to understand the social and political features of their practice contexts, opening new avenues for them to actively influence their work environments. The researcher predicts that increasing nursing engagement will improve patient care and patient outcomes in the PICU.

The author concludes that this study has demonstrated that research based on PICU nurses and their environment makes a useful contribution to research. The views and experiences of nurses as members of the PICU team must be ascertained and documented in order to enhance understanding of how best to recruit and retain these essential members of the care team in an ICU of a paediatric hospital.

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APPENDICES

Appendix A – Assumptions

Appendix B – Participant Information Sheet

Appendix C – Invitation to Participate in Research

Appendix D – Consent Form

Appendix E – Guide for Interview Questions Following Patton's Model

Appendix F – Guide Questions for Semi-Structured Interviews

Appendix G – Family Information Sheet

Appendix H – Pilot Project

Appendix I – The Story of PICU

Appendix J – Sample N-Vivo & Themes

Appendix A: Declaration of Assumptions

- Inter-professional health team members have a shared culture to be identified as the 'PICU culture'.
- PICU cultures across Canada are fluid and continually evolving, shaped by current trends in health care and society.
- The PICU culture influences nurses' decision making in some manner.
- PICU nurses and physicians are interested in providing quality care to children and their families.
- A power imbalance exists between PICU physicians and other members of the inter-professional health care team.
- A power imbalance exists between PICU inter-professional health care team members and families.
- Nurses, as a female dominated profession suffer a lack of self esteem and a lack of respect for their profession
- There is a significant power imbalance between medicine and nursing which affects their relationships.
- PCC nurses are educated to a level beyond their scope of practice which causes frustration and dissatisfaction with their jobs, positions and work environments
- Family centred care is an integral part of paediatric nursing. Family centred care implies that the nurse has a relationship with both the child and the family. This adds a different level of responsibility to the bed side nurses' work load.
- As a female dominated profession the majority of PCC nurses are of child bearing age and or have children – this may add a different dimension to their reactions to death and dying and critically ill children in general.
- Nurses are trapped in traditional role models.
- Horizontal violence exists in nursing. (*Horizontal violence: "Horizontal, or lateral violence is defined as hostile, aggressive behaviour by an individual or group towards an individual or a group"*. Duffy E. Horizontal violence: a conundrum for nursing." *Collegian*. 1995; 2 (2): 5-9, 12-17.)
- Knowledge is power.

Appendix B: Participant Information Sheet



Research Study

From the Inside Out:

A Critical Ethnographic View of Paediatric Intensive Care Nursing

Participant Information Sheet

Principal Investigator:

Paula Mahon, University of Bath

Professional Doctoral Program – Thesis

Telephone: W. (604) 875-2133 or H. (604) 731-1840

e-mail: pmahon@cw.bc.ca

Co-Investigators:

Dr. Gladys McPherson, Assistant Professor

UBC School of Nursing

Phone: (604) 822-7456

e-mail: gladys.mcpherson@nursing.ubc.ca

Dr. Claudia Mastache, Researcher/Clinical Studies Officer

University of Bath

Phone: 01225 383655

e-mail: cm257@bath.ac.uk

You have been invited to participate in a study intended to explore how features of the PICU environment influence nurses' intentions to stay or leave children's critical care bed-side nursing. You have been invited to participate in the study based upon your expertise as a health care provider working with critically ill children. It is

believed that your contributions to this study will increase our understanding of how nurses in PICUs are influenced by their work environment when making career choices.

Study Procedure

If you choose to participate in this study, you will be asked to dedicate one hour of your time for an initial interview and possibly an additional one hour for a follow-up interview. These interviews will be scheduled at a time and place convenient for you. The interviews will be audio-taped, and the audiotapes transcribed verbatim for analysis by the research team. During the interview process, you may ask questions of the researcher, you may refuse to answer any question, and you may request that recorded data be erased.

The researcher will spend time in PICU observing and documenting the PICU work environment. The researcher will pay attention to features of the work environment that shape your work. During that time the researcher will make her presence known to you and your colleagues.

Confidentiality/Risks

Every effort will be made to ensure that your identity is protected and that confidentiality is maintained. In the data, participants will be assigned a code number, and identifying information will be erased. Only the research team will have access to the electronic data and the hard copy data. The digital audio files and transcripts will be stored on a secure server, accessible only to the research team. In addition, any persons you mention on the tapes will not have their identity revealed at any time. At any time during the process, you can refuse to answer questions, and/or request that the tape be turned off or erased. You can also end your involvement in this research project at any time. If you find you need support as a consequence of participating in this project the research team will be able to support you in finding appropriate assistance.

Your rights to privacy are also protected by the Freedom of Information and Protection of Privacy Act of British Columbia. This Act lays down rules for the

collection, protection, and retention of your personal information by public bodies, such as the University of British Columbia and its affiliated teaching hospitals. Further details about this Act are available upon request.

As a nurse I am guided by the Canadian Nurses Associations' code of ethics. If you wish to review this please follow the links below:

<http://www.cna-nurses.ca/cna/>

http://www.cna-aicc.ca/CNA/practice/ethics/code/default_e.aspx.

Contact for information about the study

If you have any questions or desire further information with respect to this study, you may contact Paula Mahon at either W. (604) 875-2133 or H. (604) 731-1840 or via email at [*pmahon@cw.bc.ca*](mailto:pmahon@cw.bc.ca).

Contact for concerns about the rights of research subjects

Signing this consent form in no way limits your legal rights. If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the University of British Columbia Office of Research services at (604) 822-8598.

Appendix C: Invitation to Participate in Research



You are invited to participate in a study intended to explore how features of the PICU environment influence nurses' intentions to stay in or leave children's critical care bed-side nursing. Based upon your expertise as a health care provider working with critically ill children you are invited to participate in the study by agreeing to be interviewed by the researcher. It is believed that your contributions to this study will increase our understanding of how nurses in PICU's are influenced by their work environment when making career choices.

This research study is being conducted by Paula Mahon, a graduate student in the Doctoral program at the University of Bath, UK. This research study is intended to meet partial fulfilment of the requirements for my Doctorate degree. Dr. Gladys McPherson, UBC School of Nursing, will be my practice supervisor; Dr. Becky Palmer is the principal.

Ethics approval to conduct this study has been gained from both UBC/BCCH and the University of Bath.

Interviews with PICU nursing staff will commence in May. Those willing to participate should contact Paula by:

Email

pmahon@cw.bc.ca

Phone:

604 7311840

Or

Leave a note in Paula's mail box in ICU

The Manager has agreed that X and X (PICU CRN's) can cover your bed-side for the duration of the interview. If you wish to be interviewed outside of work hours this can be arranged.

Please remember that interviews will be recorded and ALL INTERVIEWS AND CONVERSATIONS WILL BE KEPT CONFIDENTIAL.

In thanks for your time and participation a \$20 coffee card (from a coffee shop of your choosing) will be give to each participant.

Thank you to those who have volunteered already.

For your information please find attached:

Family information sheet

Participant information sheet

Consent form

If you have any questions please feel free to speak with Paula.

Appendix D: Consent Form



Research Study

From The Inside Out:

A Critical Ethnographic View of Paediatric Intensive Care Nursing

Consent Form

Principal Investigator:

Paula Mahon, University of Bath
Professional Doctoral Program – Thesis
Telephone: W. (604) 875-2133 or H. (604) 731-1840
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Dr. Claudia Mastache, Researcher/Clinical Studies Officer
University of Bath
Phone: 01225 383655
Email: cm257@bath.ac.uk

You have been invited to participate in a study intended to explore how features of the PICU environment influence nurses' intentions to stay or leave children's critical care bed-side nursing. You have been invited to participate in the study based upon your expertise as a health care provider working with critically ill children. It is believed that your contributions to this study will increase our understanding of how nurses in PICUs are influenced by their work environment when making career choices.

Study Procedure

If you choose to participate in this study, you will be asked to dedicate one hour of your time for an initial interview and possibly an additional one hour for a follow-up interview. These interviews will be scheduled at a time and place convenient for you. The interviews will be audio-taped, and the audiotapes transcribed verbatim for analysis by the research team. During the interview process, you may ask questions of the researcher, you may refuse to answer any question, and you may request that recorded data be erased.

The researcher will spend time in PICU observing and documenting the PICU work environment. The researcher will pay attention to features of the work environment that shape your work. During that time the researcher will make her presence known to you and your colleagues.

Confidentiality/Risks

Every effort will be made to ensure that your identity is protected and that confidentiality is maintained. In the data, participants will be assigned a code number, and identifying information will be erased. Only the research team will have access to the electronic data and the hard copy data. The digital audio files and transcripts will be stored on a secure server, accessible only to the research team. In addition, any persons you mention on the tapes will not have their identity revealed at any time. At any time during the process, you can refuse to answer questions, and/or request that the tape be turned off or erased. You can also end your involvement in this research project at any time. If you find you need support as a consequence of participating in this project, the research team will be able to support you in finding appropriate assistance.

Your rights to privacy are also protected by the Freedom of Information and Protection of Privacy Act of British Columbia. This Act lays down rules for the collection, protection, and retention of your personal information by public bodies, such as the University of British Columbia and its affiliated teaching hospitals. Further details about this Act are available upon request.

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<http://www.cna-nurses.ca/cna/>

http://www.cna-aiic.ca/CNA/practice/ethics/code/default_e.aspx.

Contact for information about the study

If you have any questions or desire further information with respect to this study, you may contact Paula Mahon at either W. (604) 875-2133 or H. (604) 731-1840 or via email at pmahon@cw.bc.ca.

Contact for concerns about the rights of research subjects

Signing this consent form in no way limits your legal rights. If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the University of British Columbia Office of Research services at (604) 822-8598.

Consent

Your participation in this study must be entirely voluntary, and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment. Your signature below indicates that you have received a copy of this consent form and a *participant information sheet* for your own records. Your signature below indicates that you have had the opportunity to ask questions and that these questions have been answered to your satisfaction. Your signature below indicates that you have given permission for the information you have provided on tape during the interviews to be used in teaching materials, research journals, books, or articles. No remuneration or reimbursement for participation is offered with this study.

Signature of Participant

Date

Signature of Researcher

Date

Appendix E: Guide for Interview questions following Patton's model of Critical ethnographic questioning (2002)

This guide follows the Patton model of Critical ethnographic questioning (2002)

➤ The Behaviour or Experience Questions:

This type of question addresses human actions or ways of “doing”.

In this study these question may appear as follows:

I notice that most of the newer nurses stay together for their breaks and socialise together, as do several other groups of nurses. This is clear to everyone who observes it. Can you describe other ways these or other groups of nurses come together?

➤ Opinion or Value Questions:

This line of questioning addresses beliefs or convictions held about a Phenomenon.

In this study this may appear as follows:

In your opinion why do these nurses act this way? Or what do you believe is the value of this behaviour?

➤ Feeling Questions:

Feeling questions address emotions and passions.

In this study this may appear as follows:

How do you personally feel about this behaviour or how does this behaviour make you feel?

➤ Knowledge Questions:

This addresses the amount of knowledge the participant holds on a given subject.

In this study this may appear as follows:

What are the sociological roots of this behaviour?

➤ **Sensory Questions:**

A sensory question aims at illuminating the visceral level or reaction to a phenomenon.

In this study this may appear as follows:

How do you react in this group of peers? Do you taste, hear, smell or touch in ways that are different when you are in this group?

➤ **Background/Demographic Questions:**

This question will address the practical information concerning the distribution and size of the group being studied.

In this study this may appear as follows:

How many new nurses do you recruit to the unit each year? Are they men or women?

Appendix F: Guide Questions for semi-structured interviews

From The Inside Out: A Critical Ethnographic View of Paediatric Intensive Care Nursing.

Thank you for agreeing to participate in this research study. I have designated you a participant number. This is to ensure your privacy and confidentiality.

PARTICIPANT DEMOGRAPHICS

Participant #

Age: < 25 years
 25 - 35 years
 35 – 40 years
 40 - 45 years
 45 – 55 years
 55 – 60 years
 60 - 65 years

Sex:

Current position in your place of employment:

Educational background:

Other areas of your professional experience:

Total years in practice:

Total years in Paediatric Intensive Care:

Employment in other PICUs (location and length of time):

Experience as a parent:

If Yes: Number of Children & their ages:

Aim of Research

The aim of this work is to examine key features of the cultural context of the PICU environment as experienced by nurses, and to identify what and how these influences shape nurses' intentions to continue in or to leave nursing in this environment.

- 1) Why did you choose to work in the Unit?
- 2) Was it what you expected?
- 3) Please describe your last day in PICU. (They will be asked to reconstruct rather than remember (qualitative interviewing book).)
- 4) Is that a typical day in PICU? (Why/why not)
- 5) What keeps you here?

Appendix G: Family Information Sheet



Research Study

From the Inside Out:

A Critical Ethnographic View of Paediatric Intensive Care Nursing

Family Information Sheet

Principal Investigator:

Paula Mahon, University of Bath

Professional Doctoral Program – Thesis

Telephone: W. (604) 875-2133 or H. (604) 731-1840

Co-Investigators:

Gladys McPherson, Assistant Professor

UBC School of Nursing

Phone: (604) 822-7456

Email: gladys.mcpherson@nursing.ubc.ca

You are being given information on a research study which is being conducted in the Paediatric Critical Care Unit (PICU), as you may be on the unit during data collection times. This study intends to explore how features of the PICU environment influence nurses' intentions to remain in children's critical care bed-side nursing throughout their careers. This study will increase our understanding of how nurses in PICUs are influenced by their work environment when making career choices. The study will start in April 2010 and continue through to October 2010.

Study Procedure

You may see the researcher spending time in PICU. During this time, the researcher will be paying attention to features of the work environment that shape nurses' work.

The researcher will make her presence known to you.

Neither you nor your child will be identified or contacted during this time.

Although the researcher may be present during your conversations with the nursing staff, and your interactions with the nursing staff may be recorded, you will not be identified.

Confidentiality/Risks

Your rights to privacy are also protected by the Freedom of Information and Protection of Privacy Act of British Columbia. This Act lays down rules for the collection, protection, and retention of your personal information by public bodies, such as the University of British Columbia and its affiliated teaching hospitals. Further details about this Act are available upon request.

As a nurse I am guided by the Canadian Nurses Associations' code of ethics. If you wish to review this please follow the links below:

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Contact for concerns about the rights of research subjects

Reading this form in no way limits your legal rights. If you have any concerns about your treatment or rights, you may contact the Research Subject Information Line in the University of British Columbia Office of Research services at (604) 822-8598.

Appendix H: Pilot Project

A pilot project to refine interview questions (See interviews below and Appendix F for sample questions).

Participants:

Nurses who have left the Unit will also be included for the purpose of this pilot. This will avoid any impact on the sample size available for the main project.

Although it is recognised that previously employed nurses will have a different perspective on PCC, the purpose of this pilot was to assist in refining the researcher's interviewing skills and abilities to formulate questions as directed by Patton's model.

Recruitment and consent:

The quality and safety Co-ordinator, a former nurse in PICU, agreed to provide information to several former employees with whom she has ongoing contact, and invite them to contact the researcher if they are interested in participating in the research. Consent will be obtained from the nurses who contact the researcher (See Appendices C&D).

Data Collection:

Approximately three nurses will be interviewed using Patton's model. The interviews will be recorded. The researcher will transcribe the data following the interview. The data accumulated will not be used in the data base for the main project.

Analysis:

The interviews will be analyzed by the researcher and the project supervisors to ensure that appropriate data is being obtained and that the research is following the framework for interviewing (Polit & Hungler, 1999).

Results:

A discussion will take place between the researcher and supervisory team to analyse the researcher's technique and develop ways to improve or adjust any weakness found.

Appendix I: The Story of PICU

Walking into ICU

In order to understand the PICU one must understand its position in the hospital. ICU is considered the hub from which all other aspects may eventually gravitate. It is the source of extreme treatments and advanced technology. PICU adds an emotional component that is difficult for most people to deal with. PICU is the site of care for the sickest children in the hospital, if not the country. Therefore a certain gravitas is given to it and thus to the staff who work there.

How it feels to be PICU nurse – an insider's perspective:

As a nurse entering the hospital you change your persona to degree. You wear your name tag, which identifies you as an employee of the hospital, but more than that, it signifies you belong here. You greet people as you go by. Maybe you will stop and help a visitor who is lost, then move on down the hall to ICU. For visitors to enter ICU they must call in to the unit clerk and ask permission to enter. For staff to enter the PICU you must use your name tag to open the door, again signifying that you belong and have a certain degree of authority and a certain level of importance or power. Once inside ICU one is instructed to wash one's hands, and then you walk to a T junction, where most visitors are unclear as to whether to turn left or right, and often require some instruction. Turning right brings you to the main part of ICU. It is built in a square, the room numbers go from 1 to 22. One passes rooms 1, 2 and 3, which are isolation rooms, then on to rooms 4, 5, 6, 7 & 8 to come to the front desk. At the front desk there is usually two unit clerks and the clinical nursing coordinator (CNC) or charge nurse. There are usually several doctors in this area. The tactical centre leads off from the front desk. In this area x-rays are interpreted, family conferences and staff meetings are held, in addition it is the area where medical teaching takes place.

Behind the tactical centre at the front desk, is Bed 9. Just beyond Bed 9 to the right, is the entrance into the operating room; to the left there is a long corridor where the nursing staff have their lockers and bathrooms. The clinical coordinator, clinical nurse specialist, educator and clinical resource nurses have offices here, and there is

also an office for the staffing clerk and medical research assistant, along with a sleeping area with a physician on call.

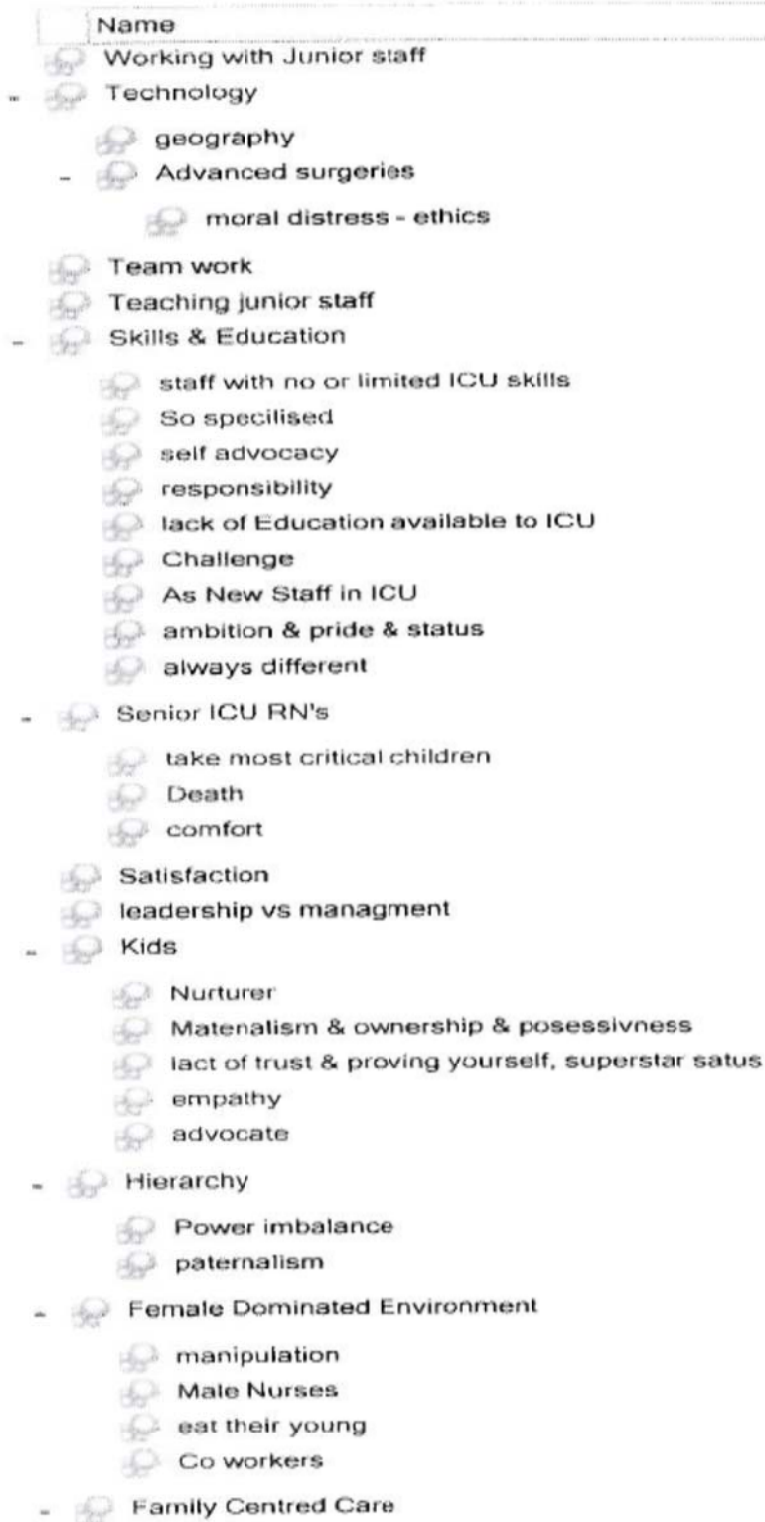
To the left of Bed 9 the beds extend to Bed 14. Bed 14 is an isolation room which is used for ECLS as this was funded separately. Glass doors lead into the area known as TCU or the transitional unit. This area cares for the more long-term, ventilator-dependent children, and consists of six beds. On the opposite side of the TCU is another set of double glass doors, beyond which are Beds 21 and 22, also isolation rooms. These rooms were recently renovated to provide appropriate ante-rooms and proper isolation facilities. This renovation was funded by the government following the SARS scare of 2003. There is a back entrance which leads to a fire escape and on into a car park.

One can feel that the general atmosphere is heightened on entry to the PICU. There is a natural sense of being in a hurry or being busy. One naturally becomes vigilant as an *insider*. In the corridor as I pass each Bed I check the child, then check the monitor and then look to see where the nurse is - all in a glance. Even if I am not “on staff” that day and I am making a social call, and realistically I have no responsibility for these children or the nurses, it is natural to me by the very fact of my being there that I have to respond and be vigilant. There is a natural personal and professional expectation that I would respond if any crisis ensued. Why I feel responsible is difficult to explain. I do not feel this response to all children, such as when I'm with my friends and their children are running around, at which time their mother is responsible, unless anything goes wrong – then even a mother will defer to my experience and knowledge. This medical knowledge is held in high esteem by the public, it is like a secret knowledge they cannot share. It tends to bring a certain degree of awe from those that do not have any medical knowledge. “Knowledge is power”



















Appendix J: Sample N-Vivo & Themes

N-VIVO

Tree Nodes



Tree Nodes

| | Name |
|---|--|
| |  time |
| |  sympathy, empathy |
| |  care of families |
| |  anxiety and violence |
| - |  Communication |
| |  Stress and Debrief |
| |  Lack of communication |
| |  continuity |
| |  #A |
| - |  Autonomy |
| - |  self scheduling |
| + |  nights |
| |  personality |
| - |  only PICU in area |
| |  it just happened |
| |  lack of due to financial constraints |
| |  floating |
| |  change |

Name: self scheduling

<Internals\Interviews\Interviews Participants A\Participant #1A> - § 3 references coded [5.83% Coverage]

Reference 1 - 2.19% Coverage

I thought there would be more collaboration. I think in Oncology I was used to a great deal of collaboration between all areas of the health care team and I didn't find that the collaboration was that strong between doctors and nurses here. I know when I first came here we were on teams so I felt more comradery and team spirit and so forth in the individual teams. But now with the self-scheduling, I'd like to say that that doesn't really occur to the same degree that it used. So I felt when I was a new ICU nurse I got a lot of support from the team that I was with. When I said oh, you know, I'm not sure how to do this, I always had somebody else to watch my back, so to speak. And people would say, oh you know, I think you're ready to do this and I'll be right beside you, so try that. It was very supportive initially.

Reference 2 - 1.41% Coverage

Did you find a difference when you came into a team environment with nurses than when you came the second time, although you probably knew a lot of the staff?

I knew a number of them, but a lot had changed, and I did find that, because when I came back to work part-time, and I did find that only working part-time I wasn't able to keep up with some of the changes sometimes. So trying to catch up on the changes and know what was different, then you'd get people sneering at you that you had to ask questions because you didn't know.

Reference 3 - 2.24% Coverage

I wanted to stay casual in ICU cause I also I don't think you should burn a bridge and one never knows. Also, in 20 years with Children's Hospital. So I don't know if it's ICU so much that I'm loathe to leave or if it's that it's 20 years at this hospital and I'm not maybe quite ready to cut the cord yet. The first time I left ICU I actually missed it. And I think I wasn't ready to leave it then, and I left because I couldn't do child care around a rotation. We didn't self-schedule back then. So then I went and did other jobs and when self-scheduling came in to ICU, I came back and this time we still have self-scheduling but I chose to leave because I think I was probably ready to leave. So I've been gone six weeks, this is my first shift back and I didn't miss it in six weeks. I missed some of the people but I haven't missed the job.

<Internals\Interviews\Participant #11> - § 1 reference coded [0.61% Coverage]

Reference 1 - 0.61% Coverage

it was difficult for me to even make the decision to come to ICU because of how fragile my schedule is the way I make it with the self-scheduling to accommodate all the volunteer stuff that I do.

<Internals\Interviews\Participant #15> - § 1 reference coded [0.78% Coverage]

Reference 1 - 0.78% Coverage

One of them it was affecting my personal life so much, the scheduling was just off, my partner works in SCN here so personal life started to become difficult

<Internals\Interviews\Participant #21> - § 2 references coded [10.88% Coverage]

Reference 1 - 8.81% Coverage

in among the mix of new staff coming, that's a whole big issue on itself. There was a whole changing to self-scheduling from teams and that created a huge issue for

learning and supporting new people. I'm the first person to not benefit by being back on teams, but I think that there would be a huge change and shift in some of the issues we experience now that would just go away if we went back to teams, because we would have regular people working with the same staff who you would know who your go-to-person is, people know how you work, how he works, and some people are weak in things and that's fine because other people are strong in things and that's just the nature and we know each other and it works. It's very difficult to work in this sort of environment where you don't know, I've been here like I said 19 years, and some people think I've only been here a few years because they've never seen me because I'm part-time. And then other people I don't know necessarily that well and what their experience is, I mean sure you have conversations, but you know, ICU is very much experiential in a lot of it and you need to work with people in their stress times, in their down times, how do they handle themselves, how do they handle sick kids, how do they handle docs, how do they handle all of the things that come with being in the ICU. That is hard to grow and grow in trust when you work sporadically with people once or twice. I

Reference 2 - 2.07% Coverage

Well, I think people wanted it. I don't think they just did it, I don't think they initiated it, it seemed like it would be a retention thing, I was on mat leave when it came out. I think it was probably looked at as a visionary step for retention. I'm not sure. I think when people have an option to look at it, it looks really great.

<Internals\Interviews\Participant #22> - § 1 reference coded [1.26% Coverage]

Reference 1 - 1.26% Coverage

At that time not every unit necessarily would have 12 hours so you'd have, especially if you were in the OR or recovery room they were more like 8 hours, so there was a strong incentive there, I liked the 12 hour shifts.

<Internals\Interviews\Participant #25> - § 1 reference coded [0.13% Coverage]

Reference 1 - 0.13% Coverage

Self-scheduling helps (laughs)

<Internals\Interviews\Participant #30> - § 1 reference coded [2.36% Coverage]

Reference 1 - 2.36% Coverage

I don't know how you're going to solve it but a team within self-scheduling maybe but I know some people like self scheduling. I think teams are better teaching environments for new staff and foster new staff much better.

<Internals\Interviews\Participant #4> - § 1 reference coded [6.04% Coverage]

Reference 1 - 6.04% Coverage

They're trying to make a team of nurses in TCU and giving us some really nice incentive actually. From the time I got to ICU, X, the TCU physician, had been asking me to work in the back. At first I thought that I needed to be able to work in the front, the more intense part of ICU, for the experience, so that if I had to work there, I could. But then I was working in the back and I really liked it because you can get really close to the patients and the families and you feel like you're doing real old-fashioned nursing. So they were trying to get core nurses to work in the back and a lot of people don't really like working in the back because I think an ICU nurse likes, it's quite

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Reference 1 - 8.81% Coverage

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